



THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301 1200

APR - 3 2008

The Honorable Richard B. Cheney
President of the Senate
Washington, DC 20510

Dear Mr. President

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year 2008 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law 104-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost-effectively improving access to, and the quality of, our health care services.

Our \$43 billion program supports the physical and mental health of 9.2 million beneficiaries worldwide, extending from theater medical care for our deployed Active and Reserve Component forces to the daily "peacetime" health services provided in our military treatment facilities or purchased in the private sector. Military Health System workload increased over the past three years and beneficiary satisfaction improved for our plan, health care, customer service, and specialty physicians, while other measures remained stable. Nine of 10 surveyed civilian physicians recognize TRICARE; eight of 10 accept patients using our Standard option. We continue to enhance the program for our patients and providers alike.

Thank you for your continued support of the Military Health System.

Sincerely,

S. Ward Casscells, MD

Enclosure
As stated



THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301 1200

APR - 3 2008

The Honorable Nancy Pelosi
Speaker of the House of Representatives
U S House of Representatives
Washington, DC 20515

Dear Madam Speaker

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year 2008 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law 104-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost-effectively improving access to, and the quality of, our health care services.

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THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR - 3 2008

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year 2008 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law 104-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost-effectively improving access to, and the quality of, our health care services.

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Sincerely,

*Respect - Gratitude,
S. Ward Casscells*

S. Ward Casscells, MD

Enclosure.
As stated

cc.
The Honorable John McCain
Ranking Member



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR - 3 2008

The Honorable Ben Nelson
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year 2008 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law 104-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost-effectively improving access to, and the quality of, our health care services.

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cc:
The Honorable Lindsey O. Graham
Ranking Member



THE ASSISTANT SECRETARY OF DEFENSE

**1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200**

HEALTH AFFAIRS

APR - 8 2008

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515-6035

Dear Mr. Chairman:

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year 2008 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law 104-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost-effectively improving access to, and the quality of, our health care services.

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cc:
The Honorable Duncan Hunter
Ranking Member



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR - 3 2008

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515-6035

Dear Madam Chairwoman:

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year 2008 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law 104-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost-effectively improving access to, and the quality of, our health care services.

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The Honorable John M. McHugh
Ranking Member



THE ASSISTANT SECRETARY OF DEFENSE

**1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200**

HEALTH AFFAIRS

APR - 3 2008

The Honorable Robert C. Byrd
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510-6025

Dear Mr. Chairman:

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year 2008 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law 104-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost-effectively improving access to, and the quality of, our health care services.

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cc
The Honorable Thad Cochran
Ranking Member



THE ASSISTANT SECRETARY OF DEFENSE

**1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200**

HEALTH AFFAIRS

APR - 3 2008

The Honorable Daniel K. Inouye
Chairman, Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510-6028

Dear Mr. Chairman:

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year 2008 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law 104-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost-effectively improving access to, and the quality of, our health care services.

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The Honorable Ted Stevens
Ranking Member



Anytime. Anywhere.

Keeping Warfighters Ready. For Life.

Evaluation of the **TRICARE** Program

FY 2008
Report to Congress



Evaluation of the **TRICARE** Program

To enhance DoD and our Nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.

FEBRUARY 29, 2008

THE FISCAL YEAR (FY) 2008 EVALUATION OF THE TRICARE PROGRAM IS PROVIDED BY:

The TRICARE Management Activity, Health Program Analysis and Evaluation Directorate (TMA/HPA&E) in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD/HA). Key agency and individual contributors to this analysis are:

Government TMA/HPA&E Project Director and Principal Coordinator:

Richard R. Bannick, Ph.D., FACHE

Government Agency Analysts and Reviewers:

TMA/HPA&E

Thomas Williams, Ph.D.
Lorraine Babeu, LTC, USA, Ph.D.
Amii Kress, M.P.H.

Data Support:

Altarum Institute

Glen Greenlee, M.A.
Joe Swedorske, M.S.
Kimberly Bellis, MSPH, M.Ed.

OASD(HA) and TMA

Robert Opsut, Ph.D.
Greg Atkinson, M.B.A.
Margaret Class, R.N.
Denise T. Green, LTC, USAF, B.S.C., M.S.
Robert Mitton, CDR, USN, D.D.S., MPH, M.B.A.
Troy Schilling, MAJ, USA, M.B.A., CDFM

Lead Analytic Support:

Institute for Defense Analyses

Philip Lurie, Ph.D.
Lawrence Goldberg, Ph.D.
Susan L. Rose, Ph.D.
R. William Cooper, M.Sc.

Contributing Analysts:

Mathematica Policy Research, Inc.

Eric Schone, Ph.D.

Final Report Production:

Forte Information Resources

Richard R. Frye, Ph.D.

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www.af.mil/photos.*

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A MESSAGE FROM S. WARD CASSCELLS, MD ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS), ASD (HA)

I am pleased to provide to the Congress this year's annual assessment of the effectiveness of TRICARE, the Department's premier health care benefits program. In addition to responding to Section 717 of the National Defense Authorization Act

(NDAA) for Fiscal Year (FY) 1996, this report allows me to report on the outcomes of our efforts addressing the six goals I've identified for FY 2007 since my appointment as Assistant Secretary of Defense for Health Affairs on April 16, 2007. These goals support the Secretary of Defense's goals and the President's Management Agenda.

Following my deployment to Iraq as a Colonel in the U.S. Army Reserves, and now approaching the end of my first year in Health Affairs, I am even more impressed with the amazing effort and accomplishments of the Military Health System (MHS), especially given the demanding operational tempo during the years since September 11, 2001, and the global reach of our humanitarian support.

In addition to responding to guiding legislation, this report offers a tremendous opportunity to report on our disciplined focus on performance results based on targeted metrics. It presents trend data over the most recent three Fiscal Years (usually FYs 2005–2007) where programs are sufficiently mature, continuing the approach used previously of comparing TRICARE with civilian-sector benchmarks where available and appropriate. This report summarizes nationwide trends under TRICARE and, unless otherwise noted, compares the U.S. (all 50 states) regions of TRICARE with comparable U.S. civilian-sector benchmarks where possible.

Some data are presented for the first time in this report, such as elements supporting our key goal of enhancing deploy-

able medical capability and force medical readiness, especially taking care of our ill and Wounded Warriors returning from operational deployment. Other data present the baseline information used to manage and sustain our benefits, assess our transformation efforts (including preparing for the Base Realignment and Closure initiatives), and monitor the effectiveness of our business information systems.

Safeguarding the health and well-being of our Service members is my top priority. The mission of the MHS in supporting the security of our nation is reflected in our commitment to individual and unit medical readiness to ensure the health and well-being of our Active Component and mobilized Reserve and Guard personnel. The Surgeons General of the Army, Navy, and Air Force and I are fully committed to the philosophy that the health and well-being of our fighting forces extend to the care and wellness of their family members, and to retirees and their family members. These beneficiaries are integral to the readiness mission and to the recruitment and retention of uniformed Service members.

The successful performance of our TRICARE health benefits program is crucial to accomplishing this mission, and I emphatically support the transparency of information helping our public, our beneficiaries, and our stakeholders understand what we are doing, how we are doing, and why we are doing what we do. To this end, I rely on our Internet Web portal to offer program information (<http://tricare.mil/>), for me to communicate directly through a routine blog (<http://www.health.mil/mhsblog.jsp>), to support the press (<http://www.tricare.mil/pressroom/>), to present our annual Stakeholder's Report (<http://www.tricare.mil/stakeholders/default.cfm>), and to archive key reports to the Congress such as this (http://www.tricare.mil/planning/congress/report_cong.cfm).

MISSION

To enhance Department of Defense (DoD) and our nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.

VISION

A world-class health system that supports the military mission by fostering, protecting, sustaining, and restoring health. There are three pillars in our strategic plan which are synergistic in creating value for our stakeholders and customers:

- Provide a medically ready and protected force and medical protection for communities.
- Create a deployable medical capability that can go anywhere, anytime, with flexibility, interoperability, and agility.
- Manage and deliver a superb health benefit.

STRATEGIC GOALS FOR FY 2007 AND THE NEXT THREE YEARS

Our MHS Strategic Plan supports our vision and guides the ongoing effort to provide high quality health care to those we serve, and to improve performance and capabilities in the near future. This strategy has six overarching goals:

Goal 1: Enhance deployable medical capability, force medical readiness, and homeland defense, including humanitarian missions (supports DoD goal of “Focus on People-Military and Civilian”):

We will enhance deployable medical capability, readiness, and homeland defense by reducing the time from “bench to battlefield” for more effective mission-focused products, processes, and services.

Goal 2: Sustain the military health benefit through quality patient-centered care and long-term patient partnerships with a focus on prevention (supports DoD goals of “Focus on People—Military and Civilian” and “Improve Effectiveness and Efficiency Across the Board”):

We will create a close partnership with our beneficiaries to improve their health, not just treat illness. Our wellness and preventive services, effective early intervention, and disease management will conserve critical resources over the long term. We know that if we do the job right the first time it will cost less in the long run, so a focus on higher quality will yield lower costs.

Since our stakeholders and our beneficiaries care deeply about preserving the military health benefit, they will work with our elected leaders and our MHS leadership to shape the benefit and achieve the appropriate balance between personal and governmental contributions.

Goal 3: Provide globally accessible, real-time health information that enables medical surveillance and evidence-based health care:

We will deploy the most advanced electronic health record in the world and create an integrated information network for the entire MHS. Our core business is DoD medical mission support, so we must lead the deployment of systems that can provide globally accessible information about the health of Service members, other beneficiaries, and entire communities.

Our system must enable early detection of medical threats by identifying patterns of symptoms before they are even identified as a disease and it must provide real-time, evidence-based decision support for our providers.

Finally, our systems must provide readiness, clinical, business, customer, financial, and other performance information to support quality outcomes and continuous process improvement.

Goal 4: Providing incentives to achieve quality in everything we do:

We will provide our leaders and managers with:

- Incentives that put quality outcomes first
- Clear direction and performance objectives to achieve both force health protection and beneficiary health care
- Alignment of authority and accountability
- A culture that promotes jointness and interagency cooperation
- Accurate transparent measurement of performance and cost
- Development and training needed to succeed in a dynamic environment

We will create a culture of continuous improvement and consistently do the simple things very well. It will free us from the bounds of excessive rules and promote operational excellence through customer-focused front-line innovation.

Goal 5: Develop our most valuable asset—our people:

We will ensure that our medical professionals meet specific capability requirements to allow us to respond with the right people at the right time to support the warfighters.

Utilizing the National Security Personnel System, we will reward performance linked to strategic and operational goals.

By seeking opportunities for our personnel to work in civilian and other Federal facilities, we will more effectively maintain skills and mission-essential capabilities while optimizing opportunities for professional development.

Our retention and recruiting efforts will focus on needed capabilities identified in the annual medical readiness review.

Goal 6: Build and sustain the best hospitals and clinics; nurture a caring environment:

Base Realignment and Closure (BRAC) provides us a singular opportunity to align critical facilities infrastructure with MHS strategic goals and objectives and will lead to improved health service delivery, increased jointness, and interoperability.

STRATEGIC GOALS FOR FY 2007 AND THE NEXT THREE YEARS (CONT'D)

The consolidation of medical centers in the national capital area and San Antonio, Texas will improve operations by reducing unnecessary infrastructure, rationalizing staff, and providing focused and tailored environments to support graduate medical education.

The elimination of inpatient services at smaller facilities in communities with adequate civilian health care resources will produce a stronger and more efficient MHS.

By bringing most medical enlisted training programs to Fort Sam Houston, San Antonio, Texas we will reduce the overall technical training infrastructure, while strengthening the consistency and quality of training across the Services.

BRAC implementation also mandates the co-location of the Service medical headquarters, reinforcing the transformation toward increased jointness.

Initiatives

- Support for BRAC implementation
- Transformed infrastructure
- Oversight of BRAC implementation plan for the Armed Forces Institute of Pathology
- Improved facility management

Areas of Focus for FY 2008 and beyond include:

- **Wounded Warrior Care:** Emphasis on better understanding and improving our ability to diagnose and treat the signature injury of our current conflict: Blast and the resultant traumatic brain injury (TBI) and psychological health issues, including posttraumatic stress disorder (PTSD).
- **Improve integration with the Department of Veterans Affairs (VA)** and support greater collaboration and seamless transitioning of disabled Service members from the military to the VA system.
- **Create patient and family-centered environments.** Our culture, processes, and design characteristics will explicitly support an environment that is compassionate, confidential, comprehensive, coordinated, clean, compatible, and controlled by the patient.
- **Implementation of BRAC** in our major markets in the national capital region and San Antonio, Texas.
- Develop interim market governance in each of these locations and proceed to develop final governance structures that respect our Service cultures while increasing interoperability.
- Continue to implement and improve our **worldwide electronic health record** system, AHLTA.

- Improve medical readiness and support the health of the warfighter anywhere, anytime.
- **Improve health and** build healthy communities.
- **Build a 21st century research capacity and health delivery systems** that can adapt and create innovative solutions for the myriad challenges we face.

EXECUTIVE SUMMARY: KEY FINDINGS FY 2007

Stakeholder Perspective

- The \$42.6 billion FY 2007 Unified Medical Program (UMP) is almost 19 percent larger than the FY 2005 expenditures of almost \$36 billion. As currently programmed, the FY 2008 budget is unchanged from the FY 2007 amount. For FY 2008, the UMP is programmed to be almost 9 percent of the total Defense budget, up from about 7 percent in FY 2005 (Ref. pages 26–27).
- The number of beneficiaries eligible for DoD medical care remained relatively constant at about 9.2 million from FY 2005 to FY 2007 (Ref. pages 20–21).
- The number of enrolled beneficiaries increased slightly from FY 2005 to FY 2007, partly due to reduced access to Prime as a result of Military Treatment Facility (MTF) closings (Ref. pages 24–25).
- The percentage of beneficiaries using MHS services increased from 78.4 percent in FY 2005 to 79.6 percent in FY 2007 (Ref. page 25).

MHS Workload and Cost Trends

- Total MHS workload increased from FY 2005 to FY 2007 for all major components—inpatient (+3 percent), outpatient (+13 percent), and retail prescription drugs (+5 percent); these increases were predominantly due to increases in purchased care workload excluding TRICARE for Life (TFL) (Ref. pages 28–29).
- Direct care inpatient and prescription workload declined and outpatient workload remained about the same from FY 2005 to FY 2007. Purchased care workload increased for all service types and costs continue to increase at double-digit rates (Ref. pages 28–29, 32).
- By the end of FY 2007, the direct care portion of total MHS health care expenditures had declined to 51 percent from about 55 percent in FY 2005. As a proportion of total MHS health care expenditures (excluding TFL), purchased care expenditures are 56 percent for prescription drugs, 53 percent for inpatient care, and 44 percent for outpatient care (Ref. page 31).
- MHS beneficiary out-of-pocket costs are more than \$3,000 less per family than their civilian counterparts (Ref. pages 51–52, 54).

MHS Provider Trends

- The number of TRICARE participating providers continues to increase but at a much slower rate than during the earlier part of this decade. The number of Prime network providers has also been increasing, both in total numbers and as a percentage of total participating providers (Ref. page 66).

Overall Customer Satisfaction With TRICARE

- Satisfaction for all MHS beneficiaries with the overall TRICARE plan, health care, and one's specialty physician has improved from FY 2005 to FY 2007, yet continues to lag civilian benchmark rates. TRICARE Prime enrollee satisfaction with the health plan increased between FY 2005 and FY 2007, for those with military as well as civilian primary care managers. Satisfaction of members enrolled with civilian network providers reported the same or higher level of satisfaction as their civilian counterparts (Ref. pages 55–56).

Building Healthy Communities

- **Meeting Preventive Care Standards:** For the past three years, the MHS has exceeded targeted Healthy People 2010 goals in providing mammograms. Efforts continue toward trying to achieve Healthy People (HP) 2010 standards for Pap smears, prenatal exams, flu shots (for people age 65 and older), and blood pressure screenings. The overall FY 2007 self-reported rates for nonsmoking (81 percent) and non-obese (76 percent) beneficiaries have remained stable over the past three years, below the desired HP 2010 adjusted goals (88 percent nonsmoking; 85 percent non-obese) (Ref. page 60).

Access to Care

- **Overall Outpatient Access.** Access to and use of outpatient services remains high, with almost 84 percent of Prime enrollees reporting having at least one outpatient visit in FY 2007 (Ref. page 62).
- **Availability and Ease of Obtaining Care.** MHS beneficiary ratings for getting necessary care and waiting for a routine appointment remained stable between FY 2005 and FY 2007, with retired beneficiaries reporting higher levels of satisfaction than Active Duty personnel or their family members (Ref. page 63).
- **Customer Service and Claims Processing.** MHS beneficiaries reported increased satisfaction with customer service in terms of understanding written materials, getting customer assistance, and dealing with paperwork between FY 2005 and FY 2007. Satisfaction with the timeliness and accuracy of claims processing increased between FY 2005 and FY 2007. The number of claims processed continues to increase, reaching more than 158 million in FY 2007. The processing of retained claims for the past six years continues to exceed the TRICARE performance standard of 95 percent retained claims processed in 30 days (Ref. pages 68–70).

NEW BENEFITS AND PROGRAMS IN FY 2007 SUPPORTING MHS STRATEGIC GOALS

TRICARE continues to meet the challenge of providing the world's finest combat medicine and aeromedical evacuation, even while providing high quality care for DoD beneficiaries at home and abroad. Since its inception more than a decade ago, TRICARE continues to offer an increasingly comprehensive health care plan to Uniformed Service members, retirees, and their families. Even as we aggressively work to sustain the TRICARE program through good fiscal stewardship, we also refine and enhance the benefit and programs in a manner consistent with industry standard of care practices and statutes to meet the changing health care needs of our beneficiaries.

Goal: Enhance Deployable Medical Capability, Force Medical Readiness and Homeland Defense, Including Humanitarian Missions

DoD Expands Mental Health Screening Guidance for Deploying Troops

The DoD issued improved policy guidance for military personnel with deployment-limiting psychiatric conditions, and for those who are prescribed psychiatric medications (December 18, 2006). The new policy satisfies many requirements established in the 2007 National Defense Authorization Act signed into law on October 17, 2006. Section 738 of the law requires the Department to specify conditions and treatments that preclude a Service member from deploying to a combat or contingency operation. Early identification and treatment of mental health problems are keys to continuation of active service and return to duty. Service personnel with psychiatric conditions in remission and without duty performance impairment are generally fit to deploy. However, these individuals must demonstrate a pattern of stability without significant symptoms for at least three months prior to deployment. Some psychiatric disorders require extensive and long-term care and treatment. These conditions will cause Service members to be unfit for duty and, therefore, routinely processed out of the military. Additionally, those deployed Service members with conditions determined to be at significant risk for performing poorly or decompensating in an operational environment who do not respond to treatment within two weeks will be returned to home station. While not altering or replacing existing accession, retention, and general fitness for duty standards, the new guidance standardizes deployment-related mental health policy across the Service branches. The guidelines stipulate that few medications are inherently disqualifying for deployment. However, lithium and anticonvulsants to control manic-depressive bipolar illness are considered disqualifying medications, as are antipsychotic drugs for psychotic, bipolar, and chronic insomnia symptoms. Psychotic and bipolar spectrum disorders are also disqualifying.

DoD Mental Health Assessment Program Serves Tens of Thousands; New Enhancements Launch in 2007

On January 22, 2007, the Office of the Deputy Assistant Secretary of Defense (Force Health Protection and

Readiness) announced the expansion of the Mental Health Self-Assessment Program (MHSAP) to better serve military families through telephone technology, Spanish language services, and youth suicide prevention programs. The MHSAP is offered to all branches and components, including National Guard and Reserve members, and provides information about services provided through both the DoD and the VA. It is run through Screening for Mental Health, Inc. (SMH), a nonprofit organization headquartered in Wellesley Hills, Massachusetts.

In 2006, tens of thousands of military families took advantage of the MHSAP, a DoD program of anonymous mental health and alcohol self-directed screenings. This enormous response is driving the addition of program enhancements to provide more services for families concerned about themselves or their children. The MHSAP provides materials designed to help installations conduct mental health and alcohol education events and an on-line self-assessment program available 24 hours a day, seven days a week to all military personnel and their families by visiting www.MilitaryMentalHealth.org. SMH is now adding a robust array of new services designed to expand the program's reach and make it more accessible and informative, to include:

- **Customizable Referrals:** Individual military bases and National Guard units will be able to add customized referrals to the on-line screening, linking individuals with local services in addition to DoD and VA mental health services.
- **On-line Assessment for Parents:** A new on-line assessment will help parents understand if their children may be suffering from depression or showing signs that could be linked with potential self-injury thoughts.
- **Telephone Self-Assessment:** To serve those who do not have ready access to the Internet, there will be a new prerecorded, interactive telephone self-assessment program. A toll-free number, 1-877-877-3647, will connect callers to the anonymous self-assessment. Callers will be provided with immediate results and phone numbers for treatment or educational resources.

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2007 (CONT'D)

- **A Pilot Spanish Language Version of the Program:** Spanish language materials will be available for in-person self-assessment, on-line screening and the new telephone component.
- **The SOS Signs of Suicide® Prevention Program will be Available for Schools located on Military Installations in the U.S. and Overseas:** The SOS program is the only school-based program proven to reduce suicide attempts in a randomized, controlled study.

Humanitarian Missions: USNS Comfort on 12-Country Humanitarian Mission to South America, Central America and the Caribbean

In August, 2007, the USNS Comfort was midway into its 120-day, 12-country deployment to the Caribbean and Central and South America, having already provided more than 170,000 consultations to over 45,000 patients in Belize, Guatemala, Panama, Nicaragua, El Salvador, and Peru. Health care services were provided by the contingent of United States Navy, Air Force, Army, Coast Guard, and U.S. Public Health Service personnel, as well as Canadian forces and nongovernmental organizations, such as Operation Smile and Project Hope. In each of these countries, doctors and nurses go ashore and set up clinics to provide primary care for children and adults, dental care, eye glasses, pharmacies, immunizations, and laboratories. Surgeons hold preoperative screenings and bring back patients to the ship for surgery and post-op recovery. During these occasions, the ship typically completes more than 20 surgeries a day in general surgery, ear, nose and throat, urology, gynecology, maxillofacial, plastics, and orthopedics. In addition, U.S. Navy Seabees carry out construction projects and repairs at hospitals, clinics, and schools, while biomedical repair technicians repair broken medical equipment and health educators conduct classes for patients and health care professionals. The Comfort's sister ship, the USNS Mercy, supported tsunami recovery operations in January 2005.

Interactive Behavioral Health Resource Launched

In a proactive approach to preventing, identifying, and treating post-deployment issues, TriWest Healthcare Alliance, the health service support contractor for the western region, launched an interactive behavioral health resource map on www.triwest.com where visitors simply click on their state and view a list of National and local, civilian, and military behavioral health resources. Service members returning from the war in Iraq now have a new resource to help them and their family members deal with the unique set of readjustment challenges they face. This

provides a fast and easy way to get help and information to those who need it no matter what time of day or where they are located. Beneficiaries who need help or know of someone who needs help—from emotional support, to counseling, financial help, or other family support—should visit the behavioral health portal, which features tools to pinpoint and address common military behavioral health issues, including PTSD, depression, substance abuse, and much more. TriWest recently expanded the portal to include a focus on child/adolescent issues, including information on depression, sleep, Attention Deficit Hyperactivity Disorder (ADHD), and other behavioral health problems a child or teen may experience as a result of a parent's military deployment.

As part of their Help from Home program, the behavioral health portal is only one of the ways TriWest is helping Service members and their families deal with the pressures of serving our nation. Help from Home proactively addresses the daunting challenge of helping Service members and their families cope with deployment-related issues. In particular, National Guard and Reserve members and their families often have limited access to behavioral health resources that are otherwise available to their Active Duty counterparts. Help from Home integrates several distinct, yet integrated, programs designed to educate, assist, and expedite support, such as National Guard and Reserve Family Readiness centers; provider education seminars about combat stress identification and treatment; sponsorship of emotionally supportive summer camps for children of deployed Service members; a variety of behavioral health pilot programs; free Getting Home DVDs with post-deployment readjustment advice and information (<http://www.triwest.com/corporate/frames.aspx?page=%2Funauth%2Fapps%2Fsearch%2Fdefault.aspx%3F&search=Help+from+Home+program?>).

Goal: Sustain the Military Health Benefit

Pharmacy Program Enhancements and Award for Innovation.

The U.S. DoD TRICARE Retail Pharmacy (TRRx) program received the Pharmacy Benefit Management Institute's 2007 Rx Benefit Innovation award for its on-line, real-time coordination of benefits (COB) program. The COB program is managed by Express Scripts and other DoD contractors. Express Scripts is one of the nation's largest pharmacy benefit management companies. The COB program simplifies the reimbursement process for beneficiaries who have drug benefit coverage with multiple sources and saves money for the DoD. This program enhancement to the TRICARE pharmacy benefit decreases the "hassle factor" of filing paper claims for thousands of beneficiaries while saving the DoD an estimated \$1 million

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2007 (CONT'D)

annually in claims processing last year. The implementation of the on-line COB program allows pharmacies to submit both primary and secondary coverage on-line for TRICARE beneficiaries, resulting in the beneficiary incurring little or no out-of-pocket expenses. Prior to the COB program, TRRx beneficiaries would have to pay for expenses not covered by their primary health insurance and then file a manual claim after the fact for reimbursement under TRICARE for their secondary coverage (http://stlouis.dbusinessnews.com/shownews.php?newsid=113922&type_news=latest). With this electronic process, TRICARE beneficiaries with other health insurance no longer have to file paper claims for prescriptions they fill at many of TRICARE's 58,000 retail network pharmacies. Retail pharmacists immediately submit electronic claims to TRICARE when a beneficiary purchases medications. Most beneficiaries now leave pharmacies with fewer out-of-pocket expenses and no requirement to file a claim. Since its inception, Express Scripts Inc., TRICARE's pharmacy contractor, electronically processed more than 850,000 prescriptions with TRICARE as a second payer. Additionally, more than 350,000 TRICARE beneficiaries took advantage of this service, and program use continues to increase at an average rate of 15 percent per week. Previously, TRICARE paid claims for beneficiaries with other health insurance through a manual process. TRICARE required beneficiaries to mail claim forms and their receipt to Express Scripts. The new process allows a pharmacy to receive TRICARE's payment before requesting a co-payment from beneficiaries.

Resolving Medicare Part D & TRICARE Eligibility for Pharmacy Benefits

In response to many beneficiary questions received, TRICARE Management Activity (TMA), the Defense Manpower Data Center (DMDC), and the Centers for Medicare and Medicaid Services (CMS) have jointly developed a customer-focused process for beneficiaries to resolve Medicare Part D and TRICARE coverage issues, and obtain their prescriptions quickly. In 2006, there were instances of dual-eligible military and Medicare beneficiaries erroneously enrolled in a Medicare Part D prescription drug plan. Affected TRICARE beneficiaries who try to use their TRICARE prescription drug benefit may not realize this occurred or may determine that enrollment in Medicare Part D is not necessary. According to Federal law, the TRICARE pharmacy benefit is considered a secondary payer to a Medicare Part D prescription drug plan. Therefore, TRICARE has established payment rules with its claims processor to ensure compliance with Federal law (<http://www.tricare.mil/pressroom/news.aspx?fid=271>).

Over the Counter Pharmacy Demonstration

On June 2007, TRICARE announced the beginning of a two-

year test authorized by the 2007 NDAA allowing TRICARE beneficiaries to substitute over-the-counter (OTC) versions of certain prescription drugs without a co-payment. For now, the test includes the TRICARE Mail Order Pharmacy only. Plans call for expansion to retail network pharmacies once program details are ironed out. The drugs included in this test initially are among the most widely prescribed—those treating gastrointestinal disorders. Known as “proton pump inhibitors,” this class of medications includes the prescription drugs Nexium, Prevacid, Aciphex, Protonix, Zegerid, and Prilosec. Under the test, beneficiaries receiving a prescription proton pump inhibitor are eligible to receive Prilosec OTC, the only proton pump inhibitor available over the counter. The DoD Pharmacy and Therapeutic Committee found there is no significant clinical difference between Prilosec OTC and its prescription-only counterparts. By requesting that their doctors prescribe the OTC version, beneficiaries can save money on their co-pay, and there is the additional potential to save the Government money as well, as OTCs are generally less expensive—by as much as 400 percent in some cases. Once the OTC test works its way to retail pharmacies, beneficiaries should not expect to walk into any drug store and get OTC products for free at the register. They will still have to get a prescription from their doctor for the OTC drugs. The DoD had published a notice in the Federal Register (<http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/E7-11558.pdf>) on June 15, 2007, to advise interested parties of the demonstration project in support of the legislated demonstration mandated by Section 705 of the John Warner National Defense Authorization Act for 2007.

Extending MHS Beneficiary Participation in Medicare's End-Stage Renal Disease Demonstration

TMA announced on April 27, 2007, that it was coordinating benefits with Medicare to make it easier for beneficiaries with end-stage renal disease to participate in three Medicare demonstrations. Medicare is offering patients with end-stage renal disease the opportunity to enroll in three demonstrations to receive integrated disease management services in multiple counties in Alabama, Arizona, California, Connecticut, Georgia, Massachusetts, Pennsylvania, Tennessee, and Texas. These demonstrations will increase the opportunity for Medicare beneficiaries with end-stage renal disease to receive integrated disease management services. The demonstrations will test the effectiveness of disease management models to increase quality of care for these patients while ensuring they receive care more effectively and efficiently. At the same time, Medicare will assess alternatives for paying for services these beneficiaries receive. TRICARE is acting as second payer for TRICARE-covered services for beneficiaries participating in these demonstrations (<http://www.tricare.mil/pressroom/news.aspx?fid=278>).

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2007 (CONT'D)

Enhanced Autism Benefit

TRICARE announced in December 2006 the creation of a plan under the Extended Care Health Option (ECHO) to provide services for military dependent children with autism. The 2007 NDAA calls for this plan to include the following:

- Education, training, and supervision requirements for individuals providing services to military dependent children with autism;
- Standards to identify and measure the availability, distribution, and training of individuals (with various levels of expertise) to provide such services; and,
- Procedures to make sure such children receive these services in addition to other publicly provided services.

Currently, there are a number of treatments available for children with autism, including Applied Behavioral Analysis (ABA). TRICARE shares the cost of ABA for an Active Duty family member (ADFM) only if a certified provider administers services. It will not cover noncertified individuals, even if a certified ABA provider indirectly supervises the individual. In the interim, TRICARE continues to share the cost of certified-provider hands-on ABA therapy, under ECHO. The TRICARE maximum allowable charge for all ECHO services is up to \$2,500 per month. Even when an ADFM sees a certified provider several hours each week, an ABA-trained family member may increase the therapy's success. To encourage family member involvement, TRICARE may cost-share family members' ABA training, if a certified provider trains them. To comply with the 2007 NDAA, TMA must create a plan under the ECHO to provide services for military dependent children with autism, which includes education, training, and supervision requirements for individuals providing services to military dependent children with autism; standards to identify and measure the availability, distribution, and training of individuals (with various levels of expertise) to provide such services; and procedures to make sure such children receive these services in addition to other publicly provided services.

Eligibility for Survivor Dental Benefits: The TMA issued an interim final rule in the *Federal Register* (<http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/E6-19437.pdf>) on November 17, 2006, implementing Section 713 of the NDAA FY 2006, Public Law 109-163, which expands the eligibility for survivor benefits under the TRICARE Dental Program (TDP) to include the active duty spouse of a member who dies while on Active Duty for a period of more than 30 days. This rule became effective November 17, 2006.

Expanded Dental Coverage for Children and Other Eligible Beneficiaries—TRICARE Medical Benefit Enhanced to Assist Dental Patients with Special Needs

On July 1, 2007, TRICARE began implementing coverage for anesthesia services and associated costs for dental treatment for beneficiaries with developmental, mental, or physical disabilities, and children age 5 or under. The NDAA of 2007 legislated the change, and TRICARE revised the regional contracts to expand coverage for the services. The services require pre-authorization through the regional TRICARE contractors. The change in statute does not provide coverage for the actual dental care services. Coverage for dental care services is available through the TRICARE Dental Program and the TRICARE Retiree Dental Program (<http://www.tricare.mil/pressroom/news.aspx?fid=247>).

TRICARE Retiree Dental Program (TRDP) exceeds 1 million covered lives:

Delta Dental of California announced in 2007 that enrollment in the TRDP exceeded 1 million covered lives, a new milestone for a program that continues as the nation's largest, voluntary, all-enrollee paid dental program. The TRDP was first authorized by Congress in 1997 and continues to offer one of the few affordable, comprehensive dental benefit programs available to the nation's Uniformed Service retirees and their family members. High satisfaction and renewal rates among existing enrollees may explain the program's growing penetration of the estimated 4 million uniformed service retirees and family members who are eligible for the program. The TRDP offers coverage for diagnostic and preventive services, basic restorative services, periodontics, endodontics, oral surgery, dental emergencies, and a separate dental accident benefit available immediately on the effective date of coverage. Additionally, the waiting period for a greater scope of benefits in the enhanced program is only 12 months, after which coverage for crowns, bridges, full/partial dentures, and orthodontics goes into effect.

TRICARE Standard Disease Management Demonstration Program

The TMA published a notice in the *Federal Register* (<http://a257.g.akamaitech.net/7/257/2422/13jun20071800/edocket.access.gpo.gov/2007/pdf/E7-11381.pdf>) announcing a MHS program entitled Disease Management Program for TRICARE Standard Beneficiaries. Although there are many similarities between TRICARE Standard and TRICARE Prime as to the preventive health care services that may be provided in the current benefit, there are services that are expressly excluded under TRICARE Standard that may be offered under TRICARE Prime, which are the essence of a DM program. TRICARE requires health care support

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2007 (CONT'D)

contractors to provide disease management services under the current contracts, without specific guidance. Based upon the legal statutes authorizing preventive health care services, TRICARE must conduct a demonstration under 10 U.S.C. 1092 in order to offer TRICARE Prime benefits to TRICARE Standard beneficiaries under the DM program already in existence. Under this demonstration, DM services will be provided to TRICARE Standard beneficiaries as part of the MHS DM programs. The demonstration project will enable the MHS to provide uniform policies and practices on disease and chronic care management throughout the TRICARE network. Additionally, the demonstration will help determine the effectiveness of DM programs in improving the health status of beneficiaries with targeted chronic diseases or conditions, and any associated cost savings. The demonstration project began April 1, 2007, and will continue until March 31, 2009.

Restructuring of TRICARE Reserve Select (TRS)

TRS is the premium-based TRICARE health plan qualified National Guard and Reserve members may purchase. The plan offers comprehensive health coverage similar to TRICARE Standard and TRICARE Extra. TRS has been available for purchase by qualifying National Guard and Reserve members since first authorized by Congress in 2005. The plan has improved every year, but changes for 2007 are the most significant yet. A streamlined TRS health care program became effective October 1, 2007, when the vast majority of National Guard and Reserve members in the Selected Reserve gained access to a robust TRS health care plan under changes mandated by the NDAA of 2007. The revamped version became simpler, with one premium level instead of the previous three-tier system. The revamped TRS also includes expanded survivor coverage, continuously open enrollment, and much more. Service agreements and differing qualifications for each of the three tiers were no longer required; instead, there are now only two qualifications for TRS under the restructured program. First, the member must be a Selected Reserve member of the Ready Reserve. Second, the member must not be eligible for the Federal Employee Health Benefits (FEHB) program or currently covered under FEHB (either under their own eligibility or through a family member with FEHB). The restructured TRS is affordable and streamlined, featuring continuously open enrollment and monthly premiums of \$81 for the Service member only option and \$253 for the Service member and family option. Coverage is comparable to TRICARE Standard and Extra. TRS information, purchase coverage instructions, and option costs are available through the "My Benefit" portal at www.tricare.mil.

Despite an instruction letter sent out in early August, 2007, less than half had transferred to the restructured program by mid-September. However, as the switch-over date neared,

the Department extended significant outreach efforts to ensure that nearly all of the 11,000 TRS members under the "tier" version of TRS would have the opportunity to continue coverage under the restructured program. Outreach efforts included up to three separate contacts via direct United States mail, a major military media campaign, and telephone calls to TRS members from Reserve component personnel and TRICARE managed care support contractors (MCSCs). By October 1, 2007, approximately 90 percent had either switched to the new program, or were in the process. The remaining Tier TRS members who had not switched to the single tier program were also permitted a 60-day window to qualify for the new program with coverage retroactive to October 1, 2007, under a new provision known as continuation coverage, although the desire was to switch personnel over before September 30, 2007, to avoid putting beneficiaries through the inconveniences that can result from disenrollment. The restructured TRS program attracted interest from members of the Selected Reserves not previously covered under the tier program, with nearly 10,000 having begun the process of qualifying for TRS by the end of the Fiscal Year. TRS members and their covered family members may access care from any TRICARE-authorized provider, hospital, or pharmacy; as well as from a military clinic or hospital on a space-available basis.

Prime Expanded to National Guard and Reserve Members Overseas On Temporary Duty

A new policy was approved March 1, 2007, making National Guard and Reserve members on temporary duty for more than 30 days eligible for TRICARE Overseas Program Prime, TRICARE Global Remote Overseas, and TRICARE Puerto Rico Prime enrollment. Previously, all National Guard and Reserve members on temporary duty for fewer than 180 days were not eligible to enroll in overseas Prime programs. They were limited to urgent and emergency care services while serving in overseas areas. National Guard and Reserve members on orders for 30 days or less will remain eligible for urgent and emergency care services in overseas areas. Family members residing with their National Guard and Reserve sponsor in overseas areas at the time of activation continue to be eligible to enroll in overseas Prime options whenever their sponsor is activated for more than 30 days. National Guard and Reserve members serving within a MTF service area are required to enroll at that MTF. Members serving in remote areas overseas must enroll in the TRICARE Global Remote Overseas program (www.tricare.mil/overseas/).

If serving in the United States territory of Puerto Rico, National Guard and Reserve members are required to enroll in TRICARE Prime Puerto Rico (www.tricare.mil/enrollment/ENRL_TPRC.doc).

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2007 (CONT'D)

Waiver of Health Insurance Premiums for Federal Employees Mobilized in Support of Contingency Military Operations

According to the *Federal Times*, Federal employees called to Active Duty in support of contingency military operations in the Middle East and elsewhere can have their health insurance premiums waived for up to two years.

All agencies have been voluntarily paying the full two years of premiums for mobilized employees enrolled in the FEHBP under a law passed in late 2004, but the Office of Personnel Management issued a final rule on February 15, 2007 in the *Federal Register* (<http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/E7-2619.pdf>) revising Federal regulations to reflect the extended benefit. Previously, employees in the National Guard and Reserves who were mobilized in support of contingency operations, such as those in Iraq and Afghanistan, could have their premiums paid by their agencies for up to 18 months. Employees who served before Congress extended the benefit from 18 months to two years could be eligible for retroactive benefits, since the change applies to operations since September 14, 2001.

About 160,000 Federal employees currently serve in the National Guard or Reserves, roughly 20 percent of the total contingent, Federal records indicate. About 550,000 National Guard and Reserve members have been mobilized since the September 11 terrorist attacks in support of contingency operations, which would translate to roughly 110,000 Federal employees.

Goal: Provide Incentives to Achieve Quality in Everything We Do

Enhancements to Organizational Structure: Joint Medical Command

On December 19, 2006, the DoD announced its new approach for governance and management of the Military Health System. Approved by Deputy Secretary of Defense Gordon England on November 27, 2006, this conceptual framework for new governance creates joint oversight and leadership of several key functional areas (education and training, medical research, health care delivery in major U.S. markets, and critical shared services) across the health system. Objectives of the new approach are to streamline operations, create greater efficiencies and cost savings, improve coordination of medical services, improve support to war-fighters, leverage better medical research, and create greater jointness and standardization in training of military medical personnel. This new approach for governance

responds to departmental direction that the Under Secretary of Defense (Personnel and Readiness), Joint Staff, and military Services work together to improve management performance and efficiency of the MHS. The transition and realignment is scheduled to be completed by 2009 (<http://www.defenselink.mil/Releases/Release.aspx?ReleaseID=10304>).

TRICARE Prime Travel Reimbursement Assists Beneficiaries Traveling for Care

TRICARE announced in August 2007 that TRICARE Prime beneficiaries referred by their primary care manager for specialty services at a location more than 100 miles from their provider's location may be eligible to have their reasonable travel expenses reimbursed by TRICARE. Beneficiaries must have a valid referral and travel orders prior to traveling, and file a travel claim upon their return. Reasonable travel expenses are the actual costs incurred by the beneficiary when traveling to their specialty provider. Costs include meals, gas, tolls, parking, and tickets for public transportation (i.e., airplane, train, bus, etc.). Beneficiaries must submit receipts for expenses above \$75. Government rates are used to estimate the reasonable cost. Beneficiaries are expected to use the least costly mode of transportation. Costs of lodging and meals may be reimbursed up to the Government per diem rate. This benefit does not apply to travel expense for specialty care experienced by Active Duty Uniformed Service members, or ADFMs residing with their sponsors overseas, which are reimbursed by other travel entitlements.

TRICARE Maximum Allowable Cost Reimbursement

The DoD TMA issued a notice in the *Federal Register* (<http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/E6-19553.pdf>) on November 20, 2006, advising interested parties of a MHS demonstration project entitled TRICARE Provider Reimbursement Demonstration Project for Alaska. The delivery of health care services in Alaska represents a unique situation that cannot be addressed fully by strictly applying the same reimbursement rules that apply to TRICARE programs in the other 49 states without some modification. Typically, provider payments are the same as under Medicare, unless the Department has taken specific action to increase payment rates in response to a particular severe access problem in a location. Under this demonstration, payment rates for physicians and other noninstitutional individual professional providers in Alaska will be set at a rate higher than the Medicare rate. The demonstration project will test the effect of this change on provider participation in TRICARE, beneficiary access to care, cost of health care services, military

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2007 (CONT'D)

medical readiness, morale, and welfare. In particular, the demonstration will test whether the increased costs of provider payments are offset in whole or part by savings in travel costs, lost duty time, and other factors. This demonstration began January 1, 2007, and will remain in effect for three years.

TRICARE Tests Paying Doctors More in Alaska

To improve access to care for its beneficiaries in Alaska, TMA began a three-year demonstration project. Beginning February 1, 2007, physicians and other noninstitutional individual professional providers in Alaska were eligible to receive payments at a rate higher than the Medicare rate. Typically, provider payments are the same as under Medicare, unless the Department has taken specific action to increase payment rates in response to a particular, severe access problem in a location. Access to health care services in Alaska is often severely limited by the overall scarcity of providers, their reluctance to accept TRICARE payment rates, transportation issues, and other factors. TRICARE is raising reimbursement rates in response to these challenges. Under this demonstration, payment rates for physicians and other noninstitutional individual professional providers in Alaska will be set at a rate higher than the Medicare rate. The demonstration project will test the effect of this change on provider participation in TRICARE; beneficiary access to care; cost of health care services; military medical readiness; morale; and welfare. In particular, the demonstration will test whether the increased costs of provider payments are offset in whole or part by savings in travel costs, lost duty time, and other factors. The original demonstration notice was published on November 20, 2006 (71 FR 67112-67113), and described a demonstration project to increase reimbursement for individual providers in Alaska. The TMA published a notice in the *Federal Register* (<http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/E7-14681.pdf>) on July 30, 2007, announcing the expansion of a MHS demonstration project to also include increased reimbursement for health care services by hospitals that have been designated as “critical access hospitals” (CAH) in Alaska. TRICARE, under the demonstration project, will reimburse CAHs in a similar manner as they are reimbursed under Medicare. The expansion of the demonstration project will test the effect of this change on CAH provider participation in TRICARE, beneficiary access to care, cost of health care services, military medical readiness, morale, and welfare. This demonstration will be conducted under statutory authority provided in 10 U.S.C. 1092. The expansion of the demonstration became effective July 1, 2007, and will continue until December 31, 2009 (three years from the date of the original demonstration).

Increases in Civilian Providers Accepting TRICARE

TRICARE’s campaign to increase the number of providers accepting TRICARE patients was successful in several states in recent years, led by the TRICARE Regional Office and TriWest Healthcare Alliance, the TRICARE health care support contractor serving 21 western states. Idaho increased the number of medical professionals signing up to accept TRICARE from about 400 to more than 2,000 in the past two years. Minnesota leadership announced the number of providers in the state increased from 485 to 4,702, and the number of hospitals in the TRICARE network from 4 to 27. In the summer of 2007, the Oregon legislature passed a tax incentive package to encourage health care providers to participate in TRICARE. Among other incentives, the package includes a one-time tax credit of \$2,500 for new providers, plus an additional annual credit of \$1,000 for treating patients enrolled in TRICARE. TRICARE increased its provider network in Oregon by 35 percent since the fall of 2004. With the encouragement and support of state leadership, the Oregon War Veterans Association and the Oregon Medical Association, there are currently more than 9,000 providers serving the 65,000 TRICARE beneficiaries in Oregon.

GAO Report Approves TRICARE Payments to Children’s Hospitals

The Government Accountability Office noted that TRICARE pays children’s hospitals the right amount for beneficiary care. The GAO’s conclusions appear self-evident in the title of the report, “Defense Health Care: Under TRICARE, Children’s Hospitals Paid More than Other Hospitals after Accounting for Patient Complexity.”

In 1988, Congress directed the DoD to establish a payment differential for children’s hospitals. The effect of the differential is to provide a significantly higher payment rate to 80 eligible hospitals nationwide. These freestanding children’s hospitals have higher costs of care for several reasons: They see very sick patients, they lack the economies of scale of major academic institutions, and they devote a higher proportion of their care to low income and Government payer patients than do other hospitals. The National Association of Children’s Hospitals recommended the addition of an inflation adjustment to the differential. In the FY 2006 NDAA, the Senate Armed Services Committee directed the GAO to assess the need for such an adjustment. On July 31, the GAO issued its report stating that an inflation adjustment of the children’s hospital payment differential is not needed. After analyzing the data available regarding complexity of care and payments for pediatric care in different types of hospitals, the GAO concluded that an increase in the TRICARE payment rate to children’s hospitals was not warranted.

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2007 (CONT'D)

Task Force on the Future of Military Health Care

The congressionally mandated Task Force on the Future of Military Healthcare began formal deliberations on January 16, 2007, during which its 14 members were briefed on the issues confronting the DoD's health care system. The 14-member task force is assigned to assess and recommend new methods for sustaining the military health care services provided to members of the Armed Forces, retirees, and their families to ensure the availability and affordability of military medicine over the long term. Under Secretary Defense (Personnel and Readiness) Dr. David S.C. Chu, and Dr. William Winkenwerder, Jr., Assistant Secretary of Defense (Health Affairs), testified at the first meeting. During a subsequent meeting, the task force examined best practices in the pharmaceutical industry, including using the mail-order pharmacy program more broadly; implementing a disease management program, which integrates the pharmacy benefit with the medical benefit; and empowering the pharmacy benefits manager to apply commercial cost saving techniques, including market share rebates.

Interagency Collaboration: Defense Department Shares Data with FDA to Enhance Medical Product Safety Reviews

The ASD (HA), announced on August 23, 2007, that the MHS data would be used to help the U.S. Food and Drug Administration (FDA) make decisions affecting the safety and use of FDA-regulated products for all Americans. The FDA, part of the U.S. Department of Health and Human Services (DHHS) and the DoD, announced a partnership to share data and expertise related to the review and use of FDA-regulated drugs, biologics, and medical devices. General patient data such as prescriptions, lab results, and patient weight will be used by the FDA to spot trends, which may identify potential concerns as well as recognize benefits of products. The two agencies will continue to protect all personal health information exchanged under the agreement, in accordance with Federal law. The partnership, which will operate under a memorandum of understanding (MOU), is part of the FDA's Sentinel Network, a medical product safety initiative first announced in January 2007. This initiative is intended to explore linking private sector and public sector information to create a virtual, integrated, electronic network. The DoD and FDA have already begun a series of meetings to establish specific procedures and safeguards necessary to implement the MOU. Long-range plans for the Sentinel Network call for a seamless national electronic information network that will include everything from new medical product information and patient care records to adverse event reports, and domestic and foreign clinical trials.

Oregon Offers Tax Credit Incentives to Health Care Providers Serving Military Families

On August 8, 2007 the leadership of the State of Oregon offered tax incentives for health care providers designed to increase access for TRICARE beneficiaries to state health care services. The legislation features a tax incentive package encouraging health care providers to support military families by participating in TRICARE. The incentives include a one-time tax credit of \$2,500 for new providers in the TRICARE system, plus an additional annual credit for treating patients enrolled in TRICARE. It also creates a deduction from Federal taxable income in the first two years of a provider's participation in the TRICARE system. TriWest Healthcare Alliance, the managed care support contractor for the TRICARE benefit in Oregon and 20 other Western States.

Goal: Develop Our Most Valuable Asset—Our People

- All Office of the Assistant Secretary of Defense (Health Affairs)/TMA civilian employees converted to the National Security Personnel System by October, 2007, successfully completing the rating cycle and leading the Department in implementing National Security Personnel System.

Landmark 21-Year Study to Track Long-Term Health of More Than 140,000 U.S. Service Members

Starting in May, 2007, the DoD launched the third and final recruitment phase of the largest prospective health project in military history: The Millennium Cohort Study. Designed to evaluate the long-term health effects of military Service, including deployments, the cohort is tracking the health status of more than 140,000 Service members from Active, Reserve, and Guard duty status until well into their civilian careers or retirement. The survey participants are chosen at random from personnel rosters of all the Service branches. While cooperation is not mandatory, the program has been endorsed by Chairman of the Joint Chiefs of Staff General Peter Pace as well as several Veterans' service organizations. While the study is entering its sixth year out of a 21-year study period, initial data has already sparked much interest in the medical community. Funded by the DoD and supported by military, VA, and civilian researchers, nearly 110,000 people are already participating in this groundbreaking study.

Overhaul of the DoD Disability Evaluation System

In 2007, the DoD began overhauling its disability evaluation system to improve its effectiveness and ensure the decisions of the Disability Advisory Council are fast and fair. The system is used to evaluate Service members' disabilities and separate or retain them, as appropriate. Service members

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2007 (CONT'D)

who are separated with at least a 30 percent disability rating receive disability retirement pay, medical benefits, and commissary privileges. With a rating below 30 percent, Veterans receive severance pay, but no benefits. In the past, each Service had its own disability evaluation system. Now DoD has put in place an overarching DoD-level framework with a single information system, Pentagon officials said. Each Service manages its caseload under that framework.

The disability process begins with medical evaluation boards at military hospitals. Attending physicians evaluate each patient, looking at conditions that may make the Service member unfit for duty. If the condition or wound is judged to make the Service member unfit, the board refers the case to a physical evaluation board. The board has a mix of medical officers and line officers. They determine if the problem is Service-related or not. The panel further recommends compensation for the injury or condition and recommends the disability rating. In FY 2006, most cases were processed within 70 days (www.defenselink.mil/news/NewsArticle.aspx?ID=3151). This effort is consistent with, and supports, the President's Commission on Care for America's Returning Wounded Warriors convened in 2007, headed by former Health and Human Services (HHS) Secretary Donna Shalala (D) and former Senator Robert Dole (R).

Goal: Provide Globally Accessible, Real-Time Health Information

HealthBeat: Bringing Beneficiaries Timely, Relevant TRICARE Benefit Information

In July, 2007, TRICARE introduced HealthBeat, its new electronic beneficiary newsletter, in conjunction with the Web site. Up-to-date benefit information combines sleek graphics to create an e-newsletter—making it easier for beneficiaries to find TRICARE news and information when they need it. This is TRICARE's first on-line beneficiary newsletter. HealthBeat links beneficiaries directly to TRICARE's most important benefit information. Among its many features, beneficiaries can find the latest TRICARE benefit updates; links to pertinent news releases and articles about TRICARE and the MHS; and the Doctor Is In column. HealthBeat resides on the My Benefits portal of the Web site, although beneficiaries do not have to subscribe to get HealthBeat (<http://tricare.mil/mybenefit/>). TRICARE sends a monthly e-mail to subscribers informing them that the latest e-newsletter has been uploaded to the My Benefits portal. The e-mail includes an overview of that issue's content with a link to the full e-newsletter on the Web site. Additionally, TRICARE periodically sends HealthBeat news flashes on benefit issues.

Electronic Surveillance System for Early Notification of Community-based Epidemics (ESSENCE) Medical Surveillance

DoD has developed an improved version of ESSENCE, a Web-based syndromic surveillance application, to examine DoD health care data for rapid or unusual increases in the frequency of certain syndromes. An increase in frequency may be a sign of diseases occurring during possible outbreaks of communicable illnesses or from the possible use of biological warfare agents.

- Local, regional, and national military officials use ESSENCE to screen for possible disease outbreaks among Service members, family members, and retirees. In the event of a possible outbreak, DoD officials are alerted and are kept informed about the results of investigations. As needed, DoD public health officials then notify their counterparts at the Department of Homeland Security, and the Centers for Disease Control and Prevention (CDC).
- ESSENCE receives and analyzes data for approximately 90,000 daily outpatient and emergency room visits in DoD health care facilities worldwide. ESSENCE sifts through the data for infectious disease syndromes occurring in patterns and trends that might need further investigation. Military public health specialists monitor the information in ESSENCE at several levels, including local installations, regional authorities, the individual armed services, and the DoD level.
- ESSENCE uses sophisticated computer methods to calculate expected rates of infectious disease syndromes in the DoD population. ESSENCE also uses standardized disease codes, or International Classification of Diseases (ICD-9) to organize patients' diagnoses into the syndromes of most interest. ESSENCE provides the MHS with the information needed to facilitate informed decision-making and enable timely response, including the allocation of any needed medical assistance, resources, and supplies to control disease outbreaks and render timely medical care to those already affected.
- The March 2, 2006, edition of *Nature* magazine features an article about the DoD overseas laboratories supporting disease epidemic preparedness, around the world. The article, "Laboratories for Global Epidemic Preparedness," discusses the work of the five laboratories comprising the DoD Global Emerging Infections Surveillance and Response System (DoD-GEIS), created by a Presidential Decision Directive in 1996. Army and Navy science and medical professionals assigned to the labs work with host nations and the World Health Organization (WHO) to improve detection and response for avian influenza and other emerging infections.

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2007 (CONT'D)

- DoD-GEIS surveillance networks play an important role in identifying and helping to contain avian influenza outbreaks in birds and people wherever they occur. Patient enrollment sites have been established in more than 20 countries in South America, the Middle East, Sub-Saharan Africa, and Central and Southeast Asia.
- In some nations, these networks provide WHO with the only information available on disease strains essential for vaccine development and pandemic preparedness. In fact, they often identify diseases where they were not previously known to occur. For example, this past year, military laboratories identified new outbreaks of dengue, an acute infectious disease transmitted by mosquitoes, in Peru, Sudan, and Yemen.
- **TRICARE Encounter Data (TED):** The congressionally mandated TED record system collects, verifies, and tracks billions of dollars annually in purchased care claims and encounter data for the MHS. TEDs are submitted by TRICARE claims processing contractors in batches for processing, and volumes frequently exceed more than 1 million records a day. TED's automated prompt processing of purchased care claims data records is a measurable incentive for more health providers to accept and treat TRICARE's 9.2 million beneficiaries. TED helps ensure that purchased care claims reimbursement is faster and more efficient by tracking claims immediately after submission, posting payments and denials, and systematically following up on unpaid claims. The result is shorter billing cycles and reimbursements paid within 30 days, one of the fastest claims processing cycles in the health care industry. In FY 2006, nearly 177 million TED records were processed for an estimated Government expenditure of more than \$13 billion.
- **AHLTA Clinical Data Repository and the VA Health Data Repository**
DoD and VA have established interoperability between the clinical data repository of AHLTA, DoD's electronic health record, and VA's Health Data Repository (HDR) of its electronic health record. The initial release of this interface, known as the Clinical/Health Data Repository (CHDR), supports the exchange of interoperable and computable health data between the Departments. During the fourth quarter FY 2006, VA and DoD successfully completed production testing and received Government acceptance of CHDR in a live patient care environment using standardized pharmacy and medication allergy data. Clinicians from the William Beaumont Army Medical Center and the El Paso VA Health Care System exchange pharmacy and medication allergy data on patients who receive health care from both health care systems. The DoD's outpatient pharmacy data exchange includes MTF pharmacy, retail pharmacy, and mail order pharmacy. The exchange of interoperable, computable, and standardized data through the CHDR interface

enables decision support which provides the ability to conduct drug-drug and drug-allergy order checking and alerting using the consolidated pharmacy and allergy data from both agencies. DoD will begin deployment and VA will continue field-testing at two additional sites in the first quarter of FY 2007 and then begin enterprise-wide implementation of this capability.

- **Pre- and Post-Deployment Health Assessments (PPDHA) and Post-Deployment Health Reassessment**

The Federal Health Information Exchange (FHIE) Program is a Federal Information Technology health care initiative that facilitates the secure electronic one-way exchange of patient medical information between Government health organizations. The project participants are the DoD and the VA. DoD has extended the FHIE capabilities to incorporate pre- and post-deployment health assessment information for separated Service members and demobilized Reserve and National Guard members. PPDHAs are provided to Active Duty Service Members and demobilized Reserve and National Guard members as they leave and return from deployment outside the U.S. In addition, a Post-Deployment Health Reassessment (PDHRA) is conducted to identify deployment-related health concerns that may arise in the three to six months after returning from deployment. This information is used to monitor the overall health condition of deployed troops, inform them of potential health risks, as well as maintain and improve the health of Service members and Veterans. As of September 2006, more than 1.4 million PPDHA forms on more than 604,000 individuals have been sent electronically from DoD to VA. Additionally, DoD has completed the historical data extraction and transfer of more than 29,000 PDHRA forms and plans to begin including these data in the monthly electronic transfer to VA beginning in the first quarter FY 2007. DoD will also begin a weekly transfer of PDHRA data for individuals referred to VA for care or evaluation as part of the PDHRA process.

- **Data Safeguards and Protections**

The TMA Privacy Office is committed to the protection of personally identifiable information. The increase in data breaches experienced throughout the government and private sector has generated increased diligence toward ensuring adequate safeguards are placed on data entrusted to the MHS. TMA accomplished the following in FY 2006:

- **MHS Notice of Privacy Practices Available On TRICARE Web Site.** In March 2006, TMA provided information on its Web site to ensure beneficiaries were made aware of the health information privacy regulation rights. Beneficiaries are made aware once

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2007 (CONT'D)

every three years both of the availability of the MHS Notice of Privacy Practices and how to obtain it. TRICARE beneficiaries may review this notice at www.tricare.osd.mil/tmaprivacy. This notification process complies with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

- All HA/TMA personnel have received refresher training on their responsibilities for safeguarding personally identifiable information. This is in addition to previously mandated annual training on the use and disclosure of health information. The Privacy Office also continues to sponsor annual conferences to train HIPAA privacy and security officers appointed to each MTF.
- An inventory of personally identifiable information within TMA was conducted with a special emphasis on internal sources that are accessed remotely or transported/stored off-site.
- Existing policies related to the access, use, or removal of data is under review. Analyses resulted in the amendment of existing policy or the creation of new documentation.
- An integrated approach to privacy and security data protection is being woven into operational and monitoring activities: Establishment of an interdisciplinary, cross-enterprise Health Information Privacy and Security Compliance Committee, incorporation of privacy and security requirements into the systems investment process of the DoD and in the VA sharing agreements.
- Data Use Agreements and Privacy Impact Assessments were analyzed to ensure data sharing outside of the organization and between information systems met appropriate standards.

NEW BENEFITS AND PROGRAMS IN FY 2007 (CONT'D)

Looking to the Future

Memo to the MHS From Dr. Casscells

August 22, 2007

A year ago today President Bush laid out a new set of goals promoting “Quality and Efficient Health Care in the Federal Government.” I am proud to report that over the last year the Department of Defense and the Department of Health and Human Services have taken up this call and led the charge for a 21st Century health care system in America.

This is an issue that I’ve felt very strongly about since I took office because, as a doctor, I think that two of the most important things we can do for our beneficiaries is, first, create a state-of-the-art health care system for them, and, second, give them the tools to let them help manage it. By involving our patients more deeply in their own care, we ultimately provide a better service.

Over the last year we have made several breakthroughs in the way we handle health care at both the DoD and around the country. These breakthroughs include a state-of-the-art pharmacy data transaction service that contains each beneficiary’s prescription list and automatically checks for drug interactions, issues alerts and reduces waste, fraud and abuse. Since we began using it in 2001, the system has saved countless lives by identifying over 200,000 cases of potentially life threatening drug interactions.

We have also leveled the playing field between doctors and patients by posting all TRICARE procedure costs on an easy-to-use Web site. This allows beneficiaries to compare our rates to those of other providers and therefore lets them judge for themselves if charges are reasonable.

In our effort to make changes outside the DoD, we have partnered with several government entities, including the VA, Department of Health and Human Services and the State of Florida. As the Federal government leads the nation toward a universal electronic medical record, we are working with our partners at the forefront of this technology to accelerate the process and create new national standards.

Yet, with all the work that’s been accomplished, even more is being planned for the coming years. I am personally overseeing projects that will improve the Health Affairs Web site, making it more interactive and user friendly. Soon you will be able to log on and share with me your opinions, concerns and criticisms.

Editor’s note: The latter feature became available soon after this memo was written.

WHAT IS TRICARE?

TRICARE is the health plan of the MHS. TRICARE responds to the challenge of maintaining medical combat readiness while providing the best health services for all eligible beneficiaries. TRICARE brings together the worldwide health resources of the Army, Navy, Air Force, Coast Guard and commissioned corps of the Public Health Service (often referred to as “direct care”), and supplements this capability with network and non-network civilian health professionals, hospitals, pharmacies, and suppliers (referred to as “purchased care”) to provide better access and high quality service while maintaining the capability to support military operations. In addition to receiving care from MTFs, where available, TRICARE offers beneficiaries three primary options:

- **TRICARE Standard** is the non-network benefit, formerly known as CHAMPUS, open to all eligible DoD beneficiaries, except Active Duty Service Members and most Medicare-eligible beneficiaries. Once eligibility is recorded in the Defense Eligibility Enrollment Reporting System (DEERS), no further application is required from our beneficiaries to obtain care from TRICARE-authorized civilian providers. An annual deductible (individual or family) and cost shares are required.
- **TRICARE Extra** is the network benefit for beneficiaries eligible for TRICARE Standard. When non-enrolled beneficiaries obtain services from TRICARE network professionals, hospitals, and suppliers, they pay the same deductible as TRICARE Standard, but TRICARE Extra cost shares are reduced by 5 percent. TRICARE network providers file claims for the beneficiary.
- **TRICARE Prime** is the HMO-like benefit offered in many areas. Each enrollee chooses or is assigned a primary care manager (PCM), a health care professional who is responsible for helping the patient manage his or her care, promoting preventive health services (e.g., routine exams, immunizations), and arranging for specialty provider services as appropriate. Access standards apply to waiting times to get an appointment, and waiting times in doctors’ offices. A point-of-service option permits enrollees to seek care from providers other than the assigned PCM without a referral, but with significantly higher deductibles and cost shares than those under TRICARE Standard.
- Some beneficiaries may qualify for other benefit options depending on their location, Active/Reserve status, and/or other factors. These options include TRICARE Reserve Select, TRICARE Prime Remote, Uniformed Services Family Health Plan (USFHP), Continued Health Care Benefit Plan, Transitional Assistance Management Program, and others. These plans typically offer benefits that are a blend of the Prime and Standard/Extra options with some limitations.

TRICARE is administered on a regional basis, with three regional contractors in the U.S. working with their TRICARE Regional Offices (TROs) to manage purchased care operations and coordinate medical services available through civilian providers with the MTFs. The TROs and regional support contracts help:

- Establish TRICARE provider networks.
- Operate TRICARE service centers and provide customer service to beneficiaries.
- Provide administrative support, such as enrollment, disenrollment, and claims processing.
- Communicate and distribute educational information to beneficiaries and providers.

BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2008

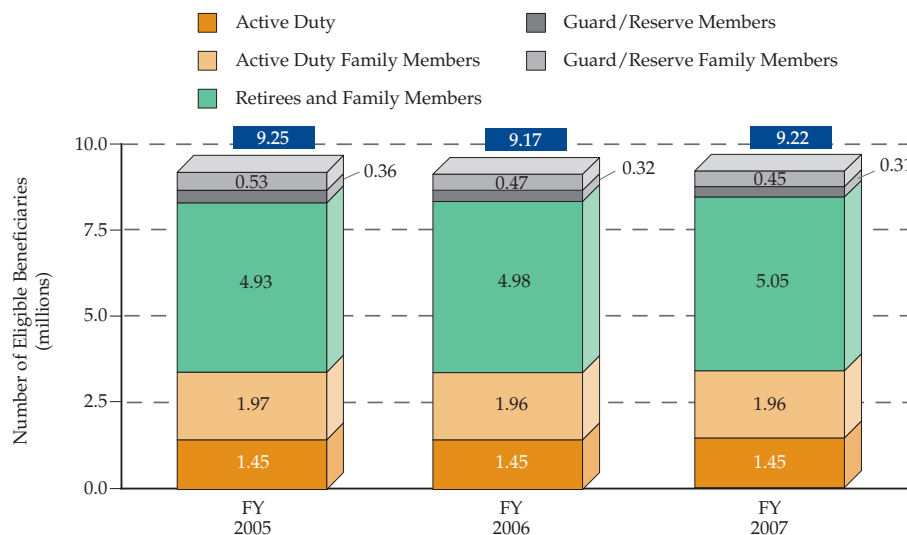
Total Beneficiaries	9.2 million*
Military Facilities—Direct Care System	
Inpatient Hospitals and Medical Centers	63 (47 in U.S.)
Ambulatory Medical Clinics	413 (317 in U.S.)
Ambulatory Dental Clinics	413 (315 in U.S.)
Veterinary Facilities	259 (239 in U.S.)
Military Health System Personnel (Defense Health Program-funded billets)	133,500
Military	89,400
Civilian	44,100
Total Unified Medical Program (UMP):	\$42.6 billion**
(Includes estimated FY 2008 receipts for Accrual Fund)	\$11.2 billion***
<p>* DoD health care beneficiary population projected for the end of FY 2008 is 9,150,492 based on the Managed Care Forecasting and Analysis System (MCFAS) as of October 22, 2007.</p> <p>** Includes direct and private sector care funding, military personnel, military construction, and the Medicare-Eligible Retiree Health Care Fund (MERHCF) ("accrual fund") DoD Normal Cost Contribution paid by the U.S. Treasury.</p> <p>*** The DoD (MERHCF), implemented in FY 2003, is an accrual fund that pays for health care provided in DoD/Coast Guard facilities to DoD retired, dependent of retired, and survivors who are Medicare-eligible beneficiaries. The fund also supports purchased care payments through the TFL benefit first implemented in FY 2002. There are three forms of contribution to Defense health care: (1) The accrual fund (\$11.2B) discussed above is paid by the military Services for future health care liability accrued since October 1, 2002, for Active Duty, Guard, and Reserve beneficiaries and their family members when they become retired and Medicare-eligible; (2) \$12.9B is paid by the Treasury to fund future health care liability accrued prior to October 1, 2001, for retired, Active Duty, Guard, and Reserves and their family members when they become retired and Medicare-eligible; and (3) \$8.349B to pay for health care benefits provided today to current Medicare-eligible retirees, family members, and survivors.</p>	

BENEFICIARY TRENDS AND DEMOGRAPHICS

Number of Eligible and Enrolled Beneficiaries Between FY 2005 and FY 2007

The number of beneficiaries eligible for DoD medical care (including TRICARE Reserve Select) declined from 9.25 million at the end of FY 2005 to 9.17 million at the end of FY 2006, but then increased to 9.22* million by the end of FY 2007. The decrease in the number of Guard/Reserve eligibles and their family members in FY 2007 was mostly offset by an increase in the number of retirees and their family members.

TRENDS IN THE END-OF-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP

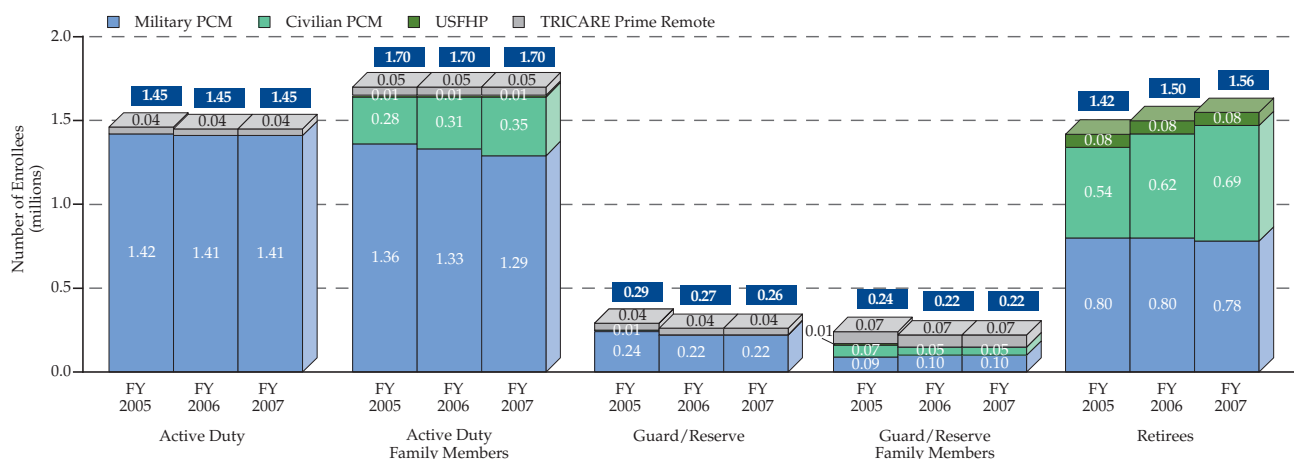


Source: DEERS 11/27/2007

* This number should not be confused with the one displayed under TRICARE FACTS AND FIGURES on page 18. The former is an actual FY 2007 total, whereas the latter is a projection for FY 2008.

- As MTFs reached capacity as a result of the mobilization of Guard/Reserve members, more enrollees were given civilian PCMs.
- Both TRICARE Prime Remote (including TRICARE Global Remote Overseas) and USFHP enrollment remained essentially constant from FY 2005 to FY 2007.

TRENDS IN THE END-OF-YEAR NUMBER OF ENROLLED BENEFICIARIES BY BENEFICIARY GROUP



Source: DEERS 11/27/2007

BENEFICIARY TRENDS AND DEMOGRAPHICS (CONT'D)

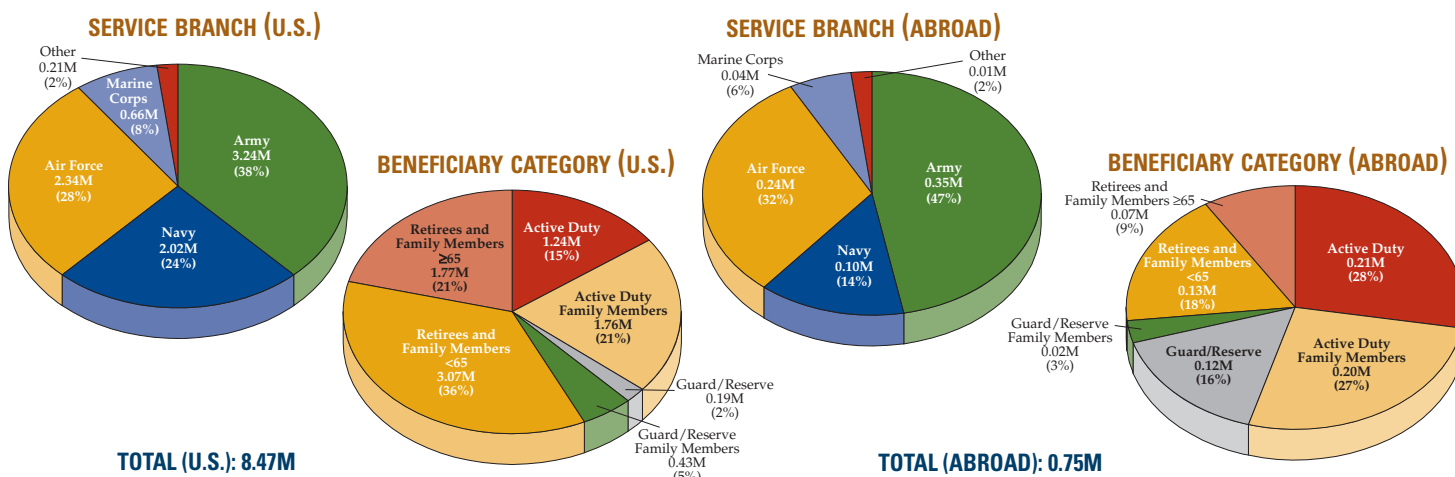
Eligible Beneficiaries in FY 2007

Of the 9.22 million eligible beneficiaries at the end of FY 2007, 8.47 million (92 percent) are stationed or reside in the United States and 0.75 million are stationed or reside abroad. The Army has the most beneficiaries eligible for Uniformed Services health care benefits, followed (in order) by the Air Force, Navy, Marine Corps, and other Uniformed Services (Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration). Although the proportions are different, the Service rankings (in terms of eligible beneficiaries) are the same abroad as they are in the U.S.

Whereas retirees and their family members comprise the largest percentage of the eligible population (57 percent) in the U.S., Active Duty personnel (including Guard/Reserve Component members on Active Duty for at least 30 days) and their family members comprise the largest percentage (73 percent) of the eligible population abroad.

Mirroring trends in the civilian population, the MHS will be confronted with an aging beneficiary population.

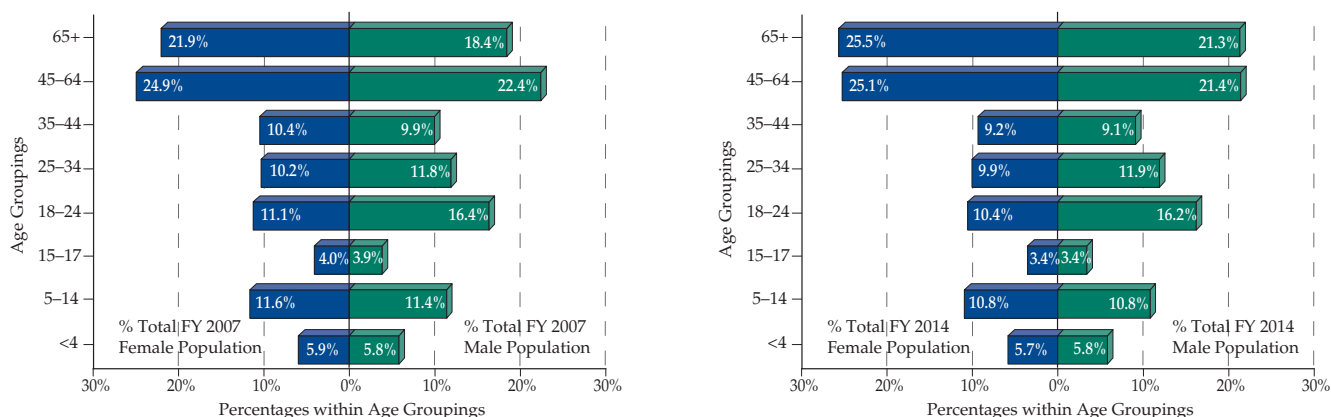
BENEFICIARIES ELIGIBLE FOR DOD HEALTH CARE BENEFITS AT THE END OF FY 2007



Source: DEERS, 11/27/2007

Note: Percentages may not add to 100 percent due to rounding.

MHS POPULATION BY AGE AND GENDER, FY 2007 AND FY 2014



TOTAL MHS POPULATION DISTRIBUTION BY AGE AND GENDER: CURRENT FY 2007 AND PROJECTED FY 2014

	Age Group (in millions)								Total by Gender	Total MHS Population
	<4	5-14	15-17	18-24	25-34	35-44	45-64	65+		
FY 2007 Female MHS Beneficiaries	0.26	0.52	0.18	0.49	0.45	0.46	1.10	0.97	4.44	9.14
FY 2007 Male MHS Beneficiaries	0.27	0.53	0.18	0.77	0.55	0.46	1.05	0.87	4.70	9.14
FY 2014 Female MHS Beneficiaries, Projected	0.25	0.48	0.15	0.46	0.44	0.41	1.11	1.13	4.44	9.00
FY 2014 Male MHS Beneficiaries, Projected	0.26	0.49	0.16	0.74	0.54	0.42	0.97	0.97	4.56	9.00

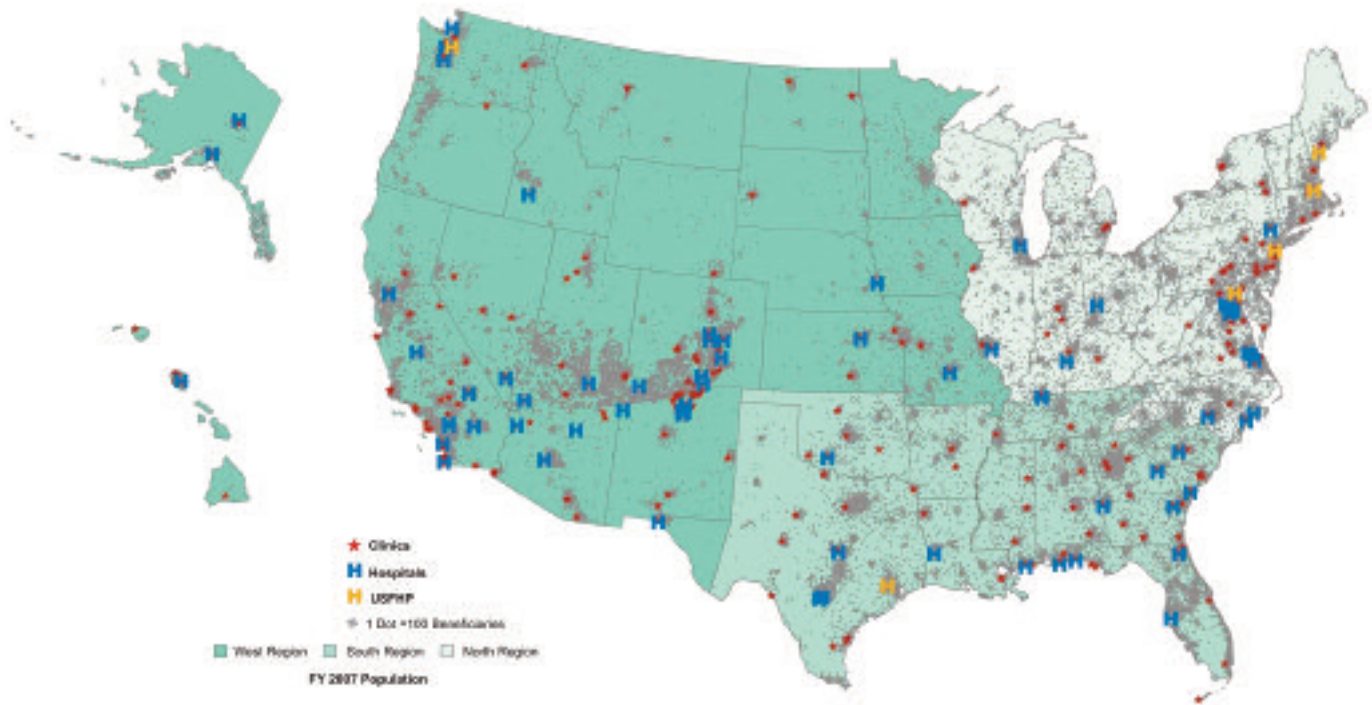
Source: MCFAS, as of 11/14/2007

BENEFICIARY TRENDS AND DEMOGRAPHICS (CONT'D)

Locations of U.S. MTFs (Hospitals and Ambulatory Care Clinics) in FY 2007

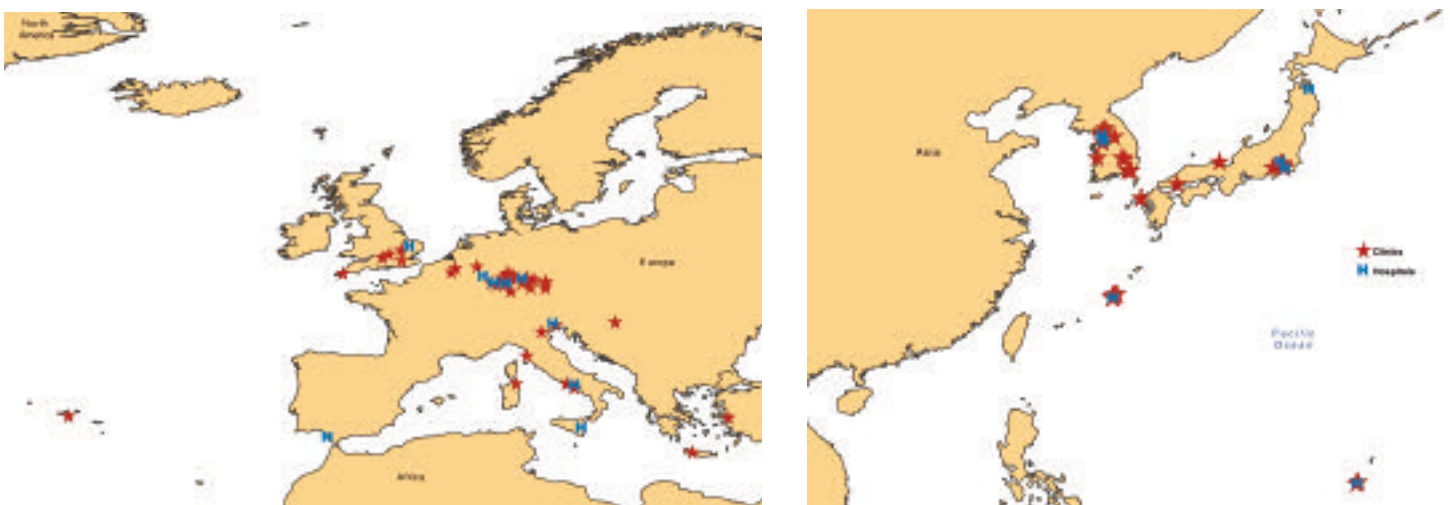
The map below presents the geographic diversity of that proportion of the MHS beneficiary population residing within the United States (92 percent of the total 9.2 million beneficiaries). An overlay of the major DoD MTFs (medical centers and community hospitals, as well as medical clinics) reflects the extent to which the MHS population has access to direct care.

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs IN FY 2007



Source: MTF information from TMA Portfolio Planning Management Division; residential population and Geographic Information Systems information from TMA/Health Program Analysis and Evaluation 11/7/2007

MTFs OUTSIDE THE U.S.



Source: MTF information from TMA Portfolio Planning Management Division; residential population and GIS information from TMA/HPA&E, 11/7/2007

Note: These two maps show only MTF locations, not population concentrations

BENEFICIARY TRENDS AND DEMOGRAPHICS (CONT'D)

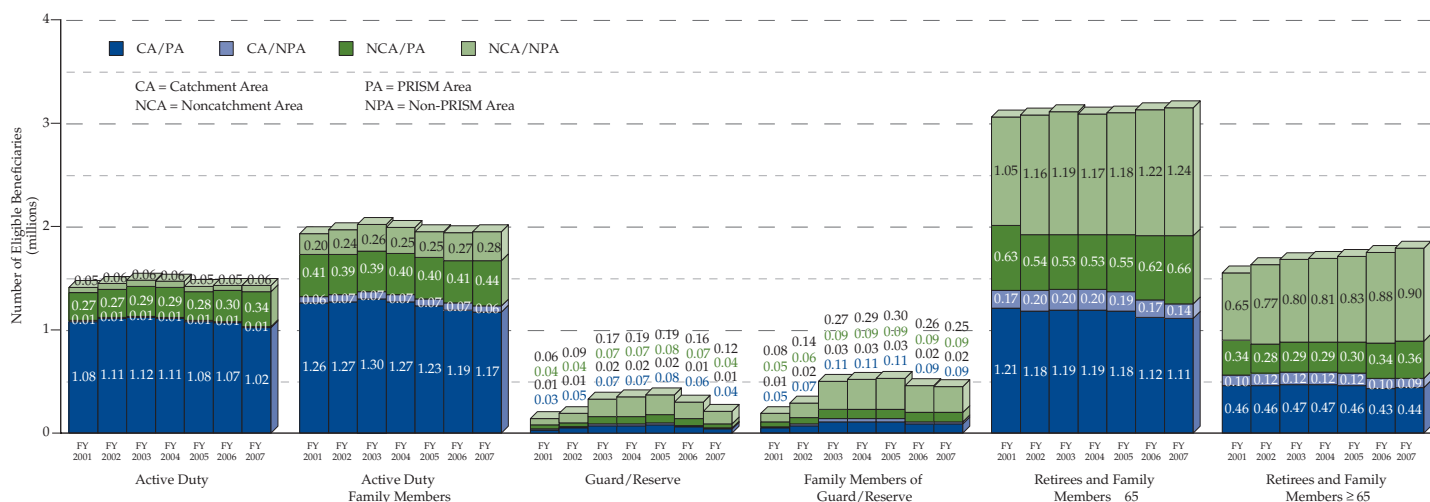
Eligible Beneficiaries Living in Catchment and PRISM Areas

Historically, military hospitals have been defined by two geographic boundaries or market areas—a 40-mile catchment area boundary for inpatient and referral care and a 20-mile PRISM (Provider Requirement Integrated Specialty Model) area boundary for outpatient care; stand-alone clinics or ambulatory care centers have only a PRISM area boundary.¹ Non-catchment and non-PRISM areas lie outside catchment area and PRISM area boundaries, respectively.

Because of Base Realignment and Closure (BRAC) actions, other facility closings and downsizings, and changes in the beneficiary mix over time, there has been a downward trend in the proportion of beneficiaries living in catchment areas (from 54 percent in FY 2001 to 47 percent in FY 2007) and PRISM areas (from 70 percent in FY 2001 to 65 percent in FY 2007). This trend has implications for the proportion of workload performed in direct care and purchased care facilities.

- More beneficiaries live in PRISM areas because, though smaller than catchment areas, they are far more numerous (about 300 PRISM areas vs. 50 catchment areas).
- There has been a decreasing trend in the number of Active Duty and retiree family members living in catchment areas.
- After declining in FY 2002, there has been a steady increase in the number of beneficiaries living in non-catchment PRISM areas.
- The mobilizations of National Guard and Reserve members have contributed disproportionately to the total number of beneficiaries living in non-catchment areas. Most Guard/Reserve members already live in non-catchment areas when recalled to Active Duty and their families continue to live there.

TREND IN THE NUMBER OF ELIGIBLE BENEFICIARIES LIVING IN AND OUT OF MTF CATCHMENT AND PRISM AREAS (END-YEAR POPULATIONS)



Source: DEERS, 11/27/2007

¹ The distance-based catchment and PRISM area concepts have been superseded within the MHS by a time-based geographic concept referred to as an MTF Enrollment Area. An MTF Enrollment Area is defined as the area within 30 minutes drive time of an MTF in which a commander may require TRICARE Prime beneficiaries to enroll with the MTF. However, because this is a relatively new concept, it has not yet been implemented within DEERS or in MHS administrative data and is consequently unavailable for use in this report.

Note: CA/PA refers to the area within 20 miles of a military hospital; it indicates proximity to both inpatient and outpatient care. CA/NPA refers to the area beyond 20 but within 40 miles of a military hospital; it indicates proximity to inpatient care only. NCA/PA refers to the area within 20 miles of a freestanding military clinic (no military hospital nearby); it indicates proximity to outpatient care only. NCA/NPA refers to the area beyond 20 miles of a freestanding military clinic; it indicates lack of proximity to either inpatient or outpatient MTF-based care.

BENEFICIARY TRENDS AND DEMOGRAPHICS (CONT'D)

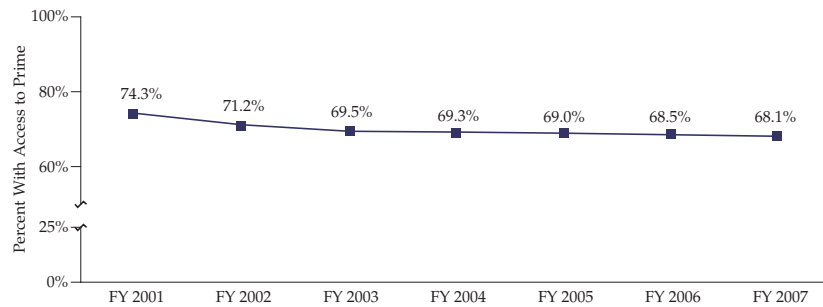
Beneficiary Access to Prime

Non-Active Duty beneficiaries living in neither a catchment nor a PRISM area have limited or no access to MTF-based Prime.

- The number of beneficiaries with access to MTF-based Prime (i.e., those living in a catchment or PRISM area) declined from 74 percent of the eligible non-Active Duty population (ADFMs and retirees and family members

under age 65) in FY 2001 to 68 percent in FY 2007. The decline is largely due to the closings of military hospitals and clinics over that time period.

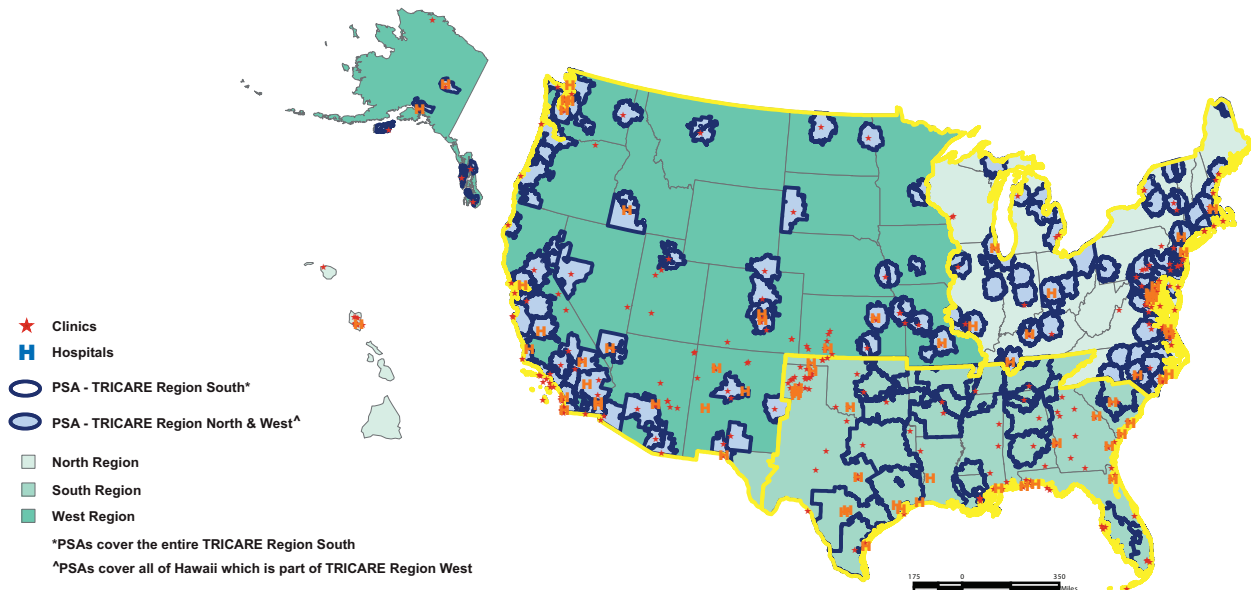
TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME



Source: DEERS, 11/27/2007

- Prime Service Areas (PSAs) are those geographic areas where the TRICARE managed care support contractors (MCSCs) offer the TRICARE Prime benefit through established networks of providers. TRICARE Prime is available at MTFs, in areas around most MTFs ("MTF PSAs"), in a number of areas where an MTF was eliminated in the Base Realignment and Closure (BRAC)

process ("BRAC PSAs"), and in some other areas where the MCSCs proposed in their contract bids to offer the benefit ("non-catchment PSAs"). The map below shows the non-catchment PSAs. Note that in the TRICARE South Region the MCSC has identified as a non-catchment PSA all portions of the region that lie outside MTF and BRAC PSAs.



Source: TRICARE Regional Office, 2/7/2008

Note: See previous page: the distance-based catchment and PRISM area concepts have been superseded within the MHS by a time-based geographic concept referred to as an MTF Enrollment Area.

BENEFICIARY TRENDS AND DEMOGRAPHICS (CONT'D)

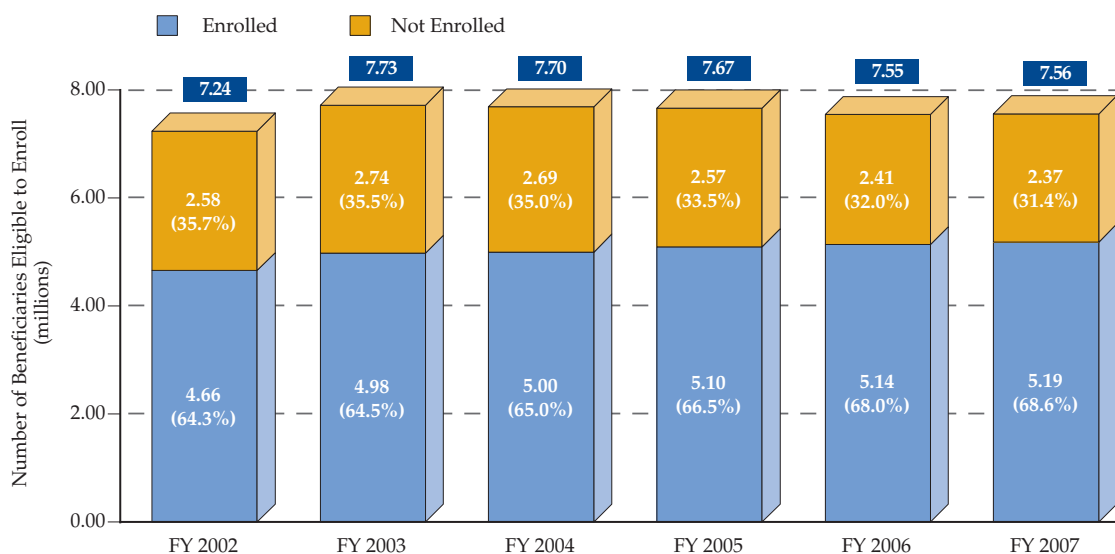
Eligibility and Enrollment in TRICARE Prime

Eligibility for and enrollment in TRICARE Prime was determined from DEERS. For the purpose of this presentation, all Active Duty personnel are considered to be enrolled. The eligibility counts exclude most beneficiaries age 65 and older (some were eligible for TRICARE Senior Prime in early FY 2002) but include beneficiaries living in remote areas where Prime may not be available. The enrollment rates displayed below may therefore be somewhat understated.

Beneficiaries enrolled in TRICARE Prime Remote (including Global Remote) and the Uniformed Services Family Health Plan are included in the enrollment counts below. Beneficiaries enrolled in TRICARE Plus (a primary care enrollment program that is offered at selected MTFs) and TRICARE Reserve Select are excluded from the enrollment counts below; they are included in the non-enrolled counts.

- In terms of total numbers, TRICARE Prime enrollment has steadily increased since FY 2002. As a percentage of those eligible to enroll, TRICARE Prime enrollment has also increased but at a slower rate.
- After peaking in FY 2005, the number of TRICARE Plus enrollees declined slightly in FY 2006 and again in FY 2007. The drop is likely due to reduced capacity for TRICARE Plus enrollment at many MTFs.
- By the end of FY 2007, 68.6 percent of all eligible beneficiaries were enrolled in Prime (5.19 million enrolled of the 7.56 million eligible to enroll).

HISTORICAL END-OF-YEAR ENROLLMENT NUMBERS



Source: DEERS, 11/27/2007

Note: Numbers may not sum to bar totals due to rounding.

BENEFICIARY TRENDS AND DEMOGRAPHICS (CONT'D)

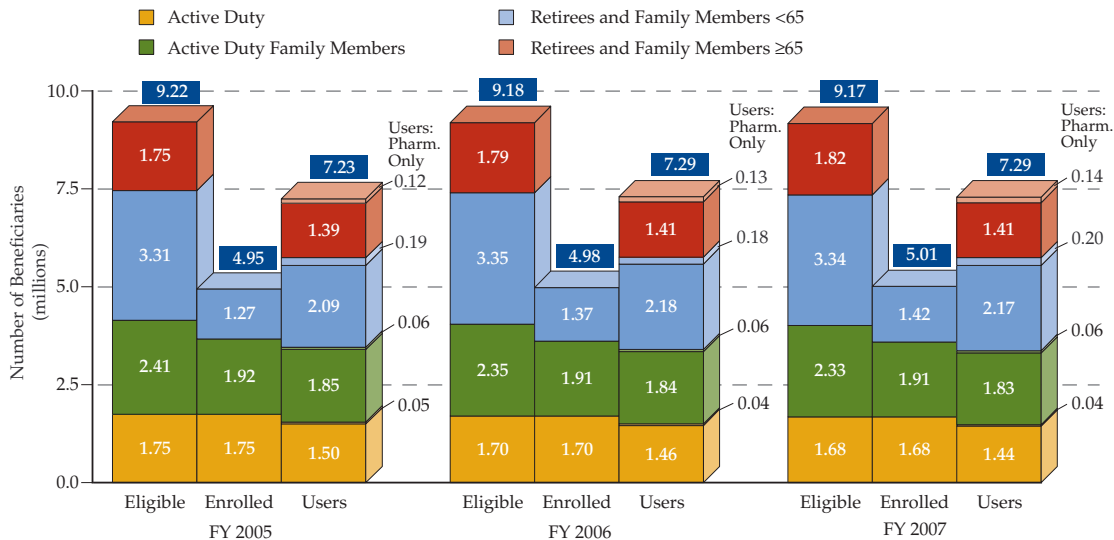
Recent Three-year Trend in Eligibles, Enrollees, Users

When calculating the number of beneficiaries eligible to use MHS services, average beneficiary counts are more relevant than end-year counts because total utilization is generated by beneficiaries eligible for any part of the year. The average numbers of eligibles and TRICARE Prime enrollees by beneficiary category from FY 2005 to FY 2007 were determined from DEERS. The eligible counts include all beneficiaries eligible for some form of the military health care benefit and, therefore, include those who may not be eligible to enroll in Prime. TRICARE Plus and Reserve Select enrollees are not included in the enrollment counts.

Two types of users are defined in this section: (1) Users of inpatient or outpatient care, regardless of pharmacy utilization; and (2) users of pharmacy only. No distinction is made here between users of direct and purchased care. The sum of the two types of users is equal to the number of beneficiaries who had any MHS utilization.

- Active Duty personnel experienced a decrease of 4 percent in the number of eligible beneficiaries between FY 2005 and FY 2007, whereas retirees and family members age 65 and older experienced an increase of 4 percent.
- The overall user rate increased from 78.4 percent in FY 2005 to 79.6 percent in FY 2007. The user rate increased slightly for ADFMs and retirees and family members under 65. The user rate remained about the same for Active Duty personnel and declined slightly for seniors.
- Retirees and family members under age 65 have the greatest number of users of the MHS but the lowest user rate. Their MHS utilization rate is lower because many of them have other health insurance.

AVERAGE NUMBER OF FY 2005 TO FY 2007 ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY

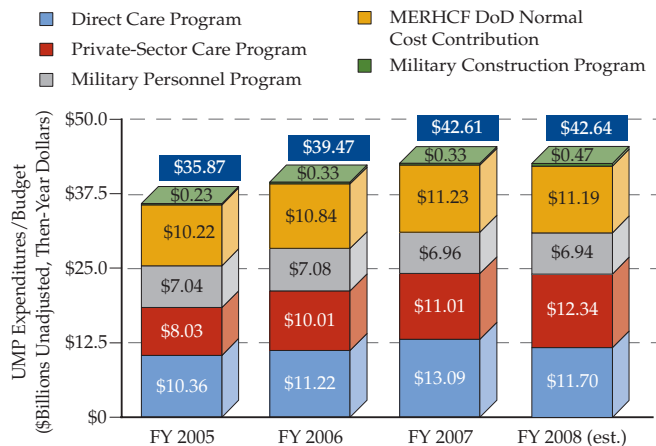


Sources: DEERS and MHS administrative data, 11/27/2007

Note: Numbers may not sum to bar totals due to rounding. The bar totals reflect the average number of eligibles and enrollees, not the end-year numbers displayed in previous charts to account for beneficiaries who were not eligible or enrolled the entire year.

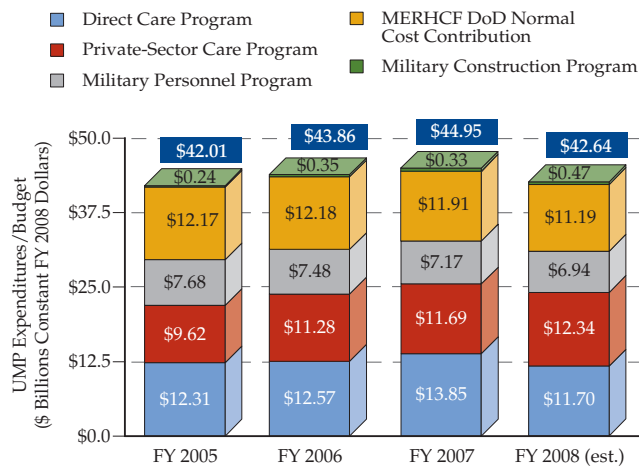
UNIFIED MEDICAL PROGRAM FUNDING

FY 2005 TO FY 2008 (EST.) UNIFIED MEDICAL PROGRAM (\$ BILLIONS) (UNADJUSTED, THEN-YEAR DOLLARS)



As shown in the first chart below, in terms of unadjusted expenditures (i.e., “then-year” dollars, unadjusted for inflation), the UMP increased from almost \$36 billion in FY 2005 to \$42.6 billion estimated for FY 2008 (as reflected in the President’s Budget Estimates). The FY 2005 to FY 2008 funding and programmed budget shown includes the normal DoD cost contribution to the MERHCF (the “Accrual Fund”). This fund (effective October 1, 2002) pays the cost of DoD health care programs for Medicare-eligible retirees, retiree family members, and survivors. Two of the major cost drivers for the Accrual Fund are the TRICARE Senior Pharmacy benefit, which began in April 2001, and the TFL benefit, which began in October 2001.

FY 2005 TO FY 2008 (EST.) UNIFIED MEDICAL PROGRAM (\$ BILLIONS) IN CONSTANT FY 2008 DOLLARS



In constant-year FY 2008 dollar funding, when actual expenditures or projected funding are adjusted for inflation, the FY 2007 purchasing value (\$45.0 billion) is 7 percent greater than the FY 2005 purchasing value (\$42.0 billion). In constant FY 2008 dollars, the FY 2008 budgeted value of \$42.6 billion is currently programmed to be 1.4 percent greater than the FY 2005 purchasing value of about \$42 billion.

Cost and Budget Estimates as of 1/16/2008.

Note: For both charts above:

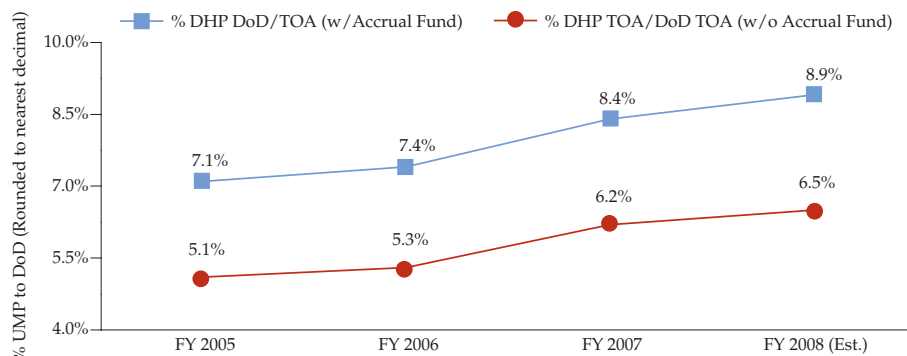
1. FYs 2005–2007 Reflect Comptroller Information System Actual execution.
2. FYs 2008–2013 reflect the FY 2009 President’s Budget Estimates as of February 2008 and includes Congressional Funding (\$2,387.1M) and partial funding for GWOT (\$575.7M).
3. Source of Data for deflators (Milpers, DHP, Procurement, RDT&E and MILCON) is Tables 5-4/5-5, Department of Defense Deflators—TOA, National Defense Budget Estimates for FY 2008 (Green Book)
4. Medicare Eligible Retiree Healthcare Fund Deflator computed using a combination of MILPER and DHP factors.
5. TRICARE for Life and other NDAA enhancements commenced in FY 2002 resulting in an approximate \$4B increase.
6. TRICARE for Life reached maturation in FY 2003.
7. FY 2005 budget includes Title IX Funding of \$683M (executed in FY 2005); \$400M for NDAA Reserve Health Care Benefit.
8. FY 2005 budget includes the FY 2004/FY 2005 Title IX Funding of \$683M (executed in FY 2005); \$210.6M in GWOT supplemental; \$20.5M for Hurricane/Tsunami Supplement.
9. FY 2006 Actuals include supplementals supporting GWOT (\$1,110.8M), Hurricane Relief (\$208.1M), Avian Flu (\$120M), and Army Modularity (\$42.8M).
10. FY 2007 Actuals include supplementals (\$2,528M) supporting GWOT and other programs such as TBI/PH, Wounded Warrior and Pandemic Influenza.

UNIFIED MEDICAL PROGRAM FUNDING

UMP Share of Defense Budget

UMP expenditures are expected to increase from 7.1 percent of DoD Total Obligational Authority (TOA) in FY 2005 to 8.9 percent estimated for FY 2008, including the Accrual Fund (as currently reflected in the FYs 2009–2013 President's Budget Request). When the Accrual Fund is excluded, the UMP's share is expected to increase from 5.1 percent in FY 2005 to 6.5 percent in FY 2008.

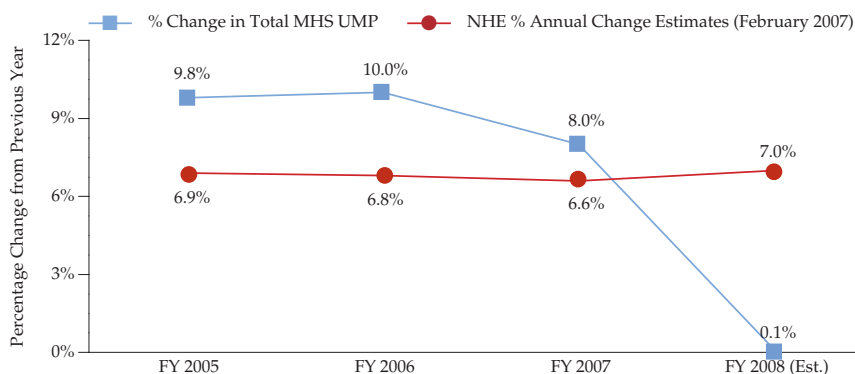
UMP EXPENDITURES AS A PERCENTAGE OF DEFENSE BUDGET: FY 2005 TO FY 2008 (EST.)



Comparison of Unified Medical Program and National Health Expenditures Over Time

The estimated rate of growth in HHS estimates of National Health Expenditures (NHE) has been stable at about 7 percent since FY 2005. The annual rate of growth in the UMP has exceeded the rate of growth in NHE for the past three years but appears to be narrowing through FY 2007 (actual for the UMP, estimated for NHE). As currently programmed, the FY 2008 budget will be substantially below the estimated growth of national health expenditures. As noted in previous annual reports, the UMP grew significantly with the establishment of the MERHCF in October 2002. Since that time, this growth may be attributed to additional funding for the Global War on Terror and the influx of Guard and Reservists and their family members eligible for and using TRICARE and disaster relief.

COMPARISON OF CHANGE IN ANNUAL UMP AND NHE OVER TIME: FY 2005 TO FY 2008 (EST.)



National Health Expenditures based on Dept. of Health and Human Services estimates are from Posal, J.A., Truffer, C. et al. (2007), "Health spending projects through 2016: Modest changes obscure Part D's impact, Exhibit 1," "National Health Expenditures (NHE), Selected Calendar years 1993–2016," and associated Web-based table, DOI 10.1377/hlthaff.262.w242. Full table obtained November 30, 2007 from http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp. Actual expenditures (in \$ billions): 2002 (\$1,602.8), 2003 (\$1,733.4), 2004 (\$1,804.7), 2005 (\$1,858.9); projected expenditures: 2006 (\$2,122.5), 2007 (\$2,262.3) and 2008 (\$2,420.0).

Cost and Budget Estimates as of 1/16/2008.

Note: For both charts above:

1. FYs 2005–2007 Reflect Comptroller Information System Actual execution.
2. FYs 2008–2013 reflect the FY 2009 President's Budget Estimates as of February 2008 and includes Congressional Funding (\$2,387.1M) and partial funding for GWOT (\$575.7M).
3. Source of Data for deflators (Milpers, DHP, Procurement, RDT&E and MILCON) is Tables 5-4/5-5, Department of Defense Deflators—TOA, National Defense Budget Estimates for FY 2008 (Green Book)
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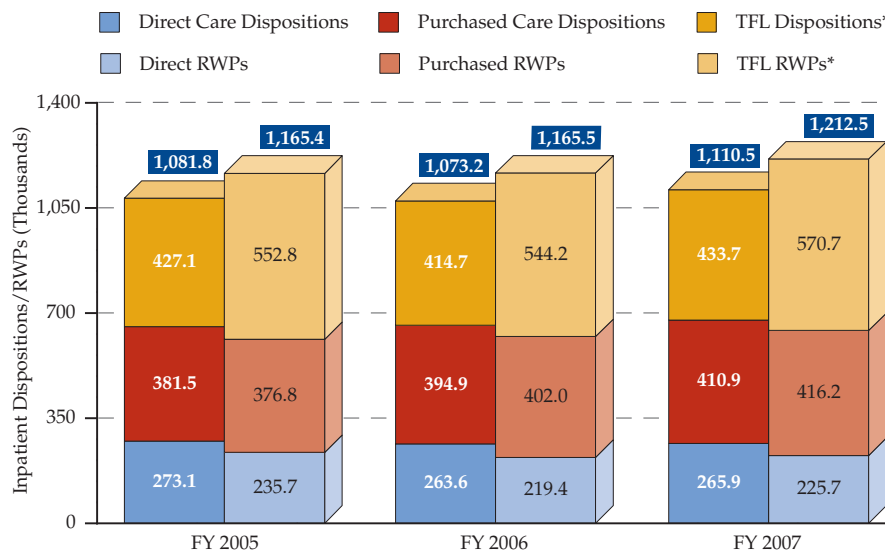
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE)

MHS Inpatient Workload

Total MHS inpatient workload is measured two ways: As the number of inpatient dispositions and as the number of relative weighted products (RWP). The latter measure, relevant only for acute care hospitals, reflects the relative resources consumed by a hospitalization as compared with the average of all hospitalizations. It gives greater weight to procedures that are more complex and involve greater lengths of stay. Total inpatient workload (direct and purchased-care combined) increased between FY 2005 and FY 2007 (dispositions increased by 3 percent and RWPs by 5 percent), excluding the effect of TFL.

- Direct care inpatient dispositions declined by 3 percent and RWPs declined by 4 percent over the past three years. This can be largely attributed to a 12 percent decline in the number of MTFs performing inpatient workload over this period.
- Excluding TFL workload, purchased care inpatient dispositions increased by 8 percent and RWPs by 10 percent from FY 2005 to FY 2007.
- Including TFL workload, purchased care dispositions increased by 4 percent and RWPs by 6 percent between FY 2005 and FY 2007.
- While not shown, about 12 percent of direct care inpatient dispositions and 11 percent of RWPs were performed abroad during FYs 2005–2007. Purchased care and TFL inpatient workload performed abroad accounted for less than 4 percent of the worldwide total.

TRENDS IN MHS INPATIENT WORKLOAD



Source: MHS administrative data, 1/5/2008

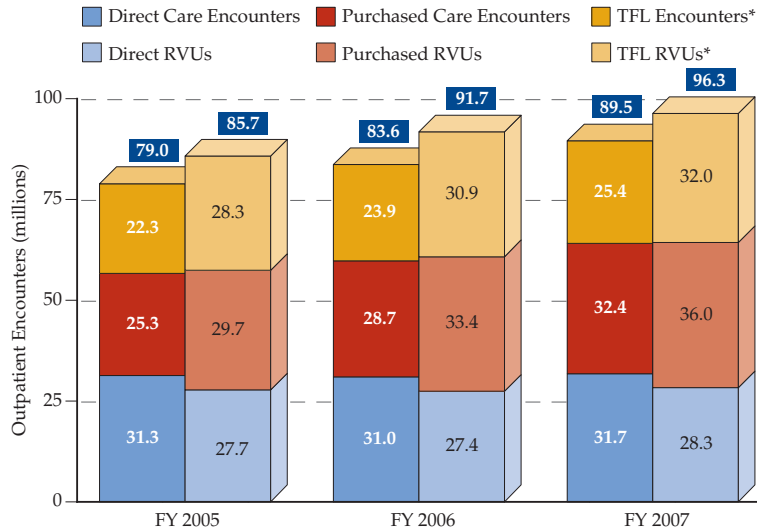
* Purchased care only

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) (CONT'D)

MHS Outpatient Workload

Total MHS outpatient workload is measured two ways: As the number of encounters (outpatient visits and ambulatory procedures) and as the number of relative value units (RVUs). The latter measure reflects the relative resources consumed by an encounter as compared to the average of all encounters. Total outpatient workload (direct and purchased care combined) increased between FY 2005 and FY 2007 (encounters increased by 13 percent and RVUs by 12 percent), excluding the effect of TFL.

TRENDS IN MHS OUTPATIENT WORKLOAD



Source: MHS administrative data, 1/5/2008

* Purchased care only.

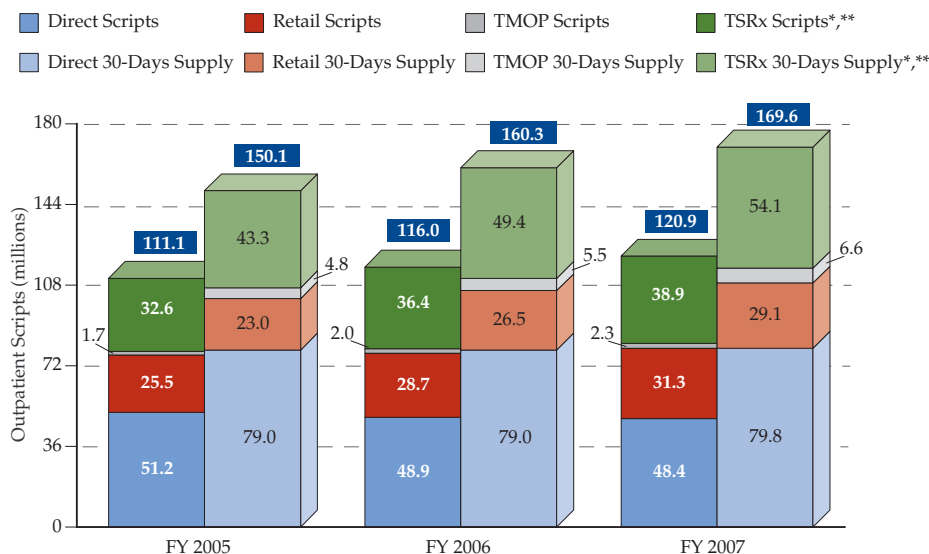
- Direct care outpatient encounters increased by 1 percent and RVUs by 2 percent over the past three years, indicating MTF workload intensity has remained essentially unchanged.
- Excluding TFL workload, purchased care outpatient encounters increased by 28 percent and RVUs by 21 percent. Including TFL workload, encounters increased by 21 percent and RVUs by 17 percent.
- While not shown, about 13 percent of direct care outpatient workload (both encounters and RVUs) was performed abroad. Purchased care and TFL outpatient workload performed abroad accounted for only about 1 percent of the worldwide total.

Note: The Centers for Medicare and Medicaid Services (CMS) recently completed a quinquennial study of payment policies for professional services that resulted in a "re-baselining" of RVUs. Consequently, part of any observed changes in FY 2007 RVUs are artificial and can be attributed directly to the change in weights and not necessarily volume or complexity of services. FY 2007 RVUs were therefore adjusted to reflect the FY 2006 RVU weights.

MHS Prescription Drug Workload

Total MHS outpatient prescription workload is measured two ways: As the number of prescriptions and as the number of days supply (in 30-day increments). Total prescription drug workload (direct and purchased care combined) increased between FY 2005 and FY 2007 (scripts increased by 5 percent and days supply by 8 percent), excluding the effect of TRICARE Senior Pharmacy.

TRENDS IN MHS PRESCRIPTION WORKLOAD



Source: MHS administrative data, 1/5/2008

* TMOP workload for TFL-eligible beneficiaries is included in the TSRx total.

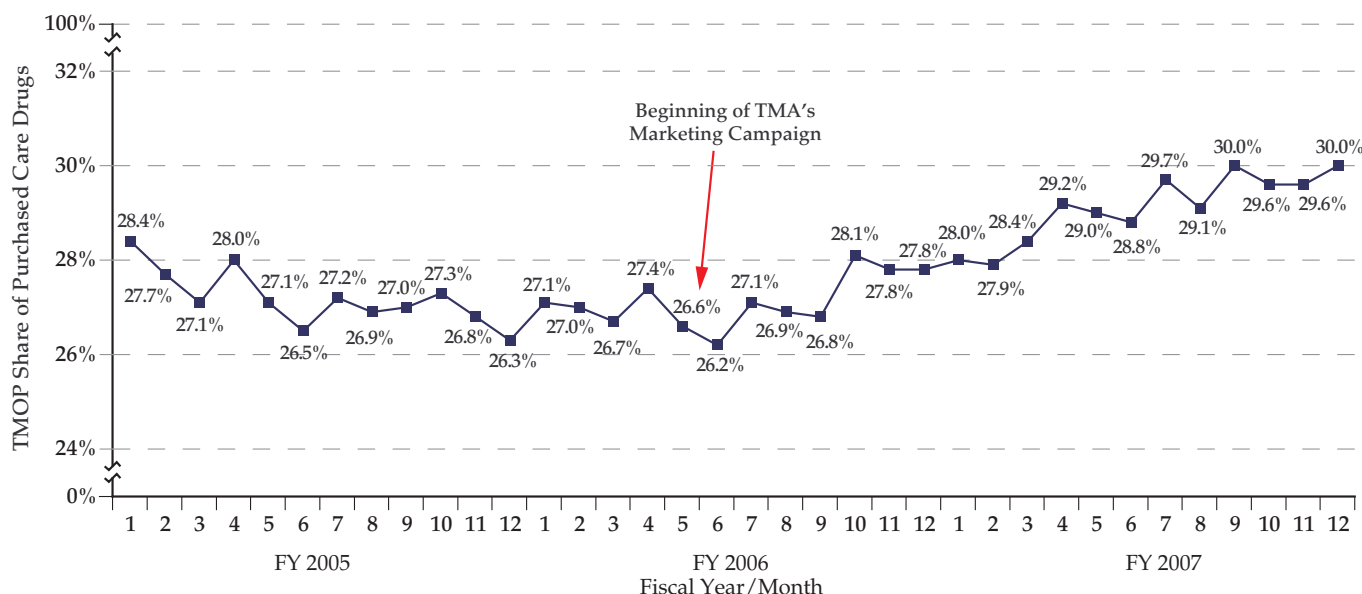
** Purchased care only.

- Direct care scripts fell by 5 percent but days supply increased by 1 percent between FY 2005 and FY 2007.
- Purchased care scripts increased by 24 percent and days supply by 28 percent from FY 2005 to FY 2007, excluding the impact of the TSRx benefit. Including the impact of TSRx, purchased scripts increased by 21 percent and days supply by 26 percent.
- While not shown, more than 7 percent of direct care prescriptions were issued abroad. Purchased care prescriptions issued abroad accounted for slightly more than 1 percent of the worldwide total.

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) (CONT'D)

Although the TRICARE Mail Order Pharmacy (TMOP) and its predecessor, the National Mail Order Pharmacy, have been available to DoD beneficiaries since the late '90s, they have never been heavily used. TMOP offers benefits to both DoD and its beneficiaries since DoD negotiates prices that are considerably lower than those for retail drugs and the beneficiary receives up to a 90-day supply for the same co-pay as a 30-day supply at a retail pharmacy. Concerned that beneficiaries were not taking advantage of a good benefit, DoD launched a marketing campaign in February 2006 to increase beneficiary awareness of the benefits offered by the TMOP.

TREND IN TMOP UTILIZATION (DAYS SUPPLY) AS A SHARE OF TOTAL PURCHASED CARE UTILIZATION



Source: MHS administrative data, 1/5/2008

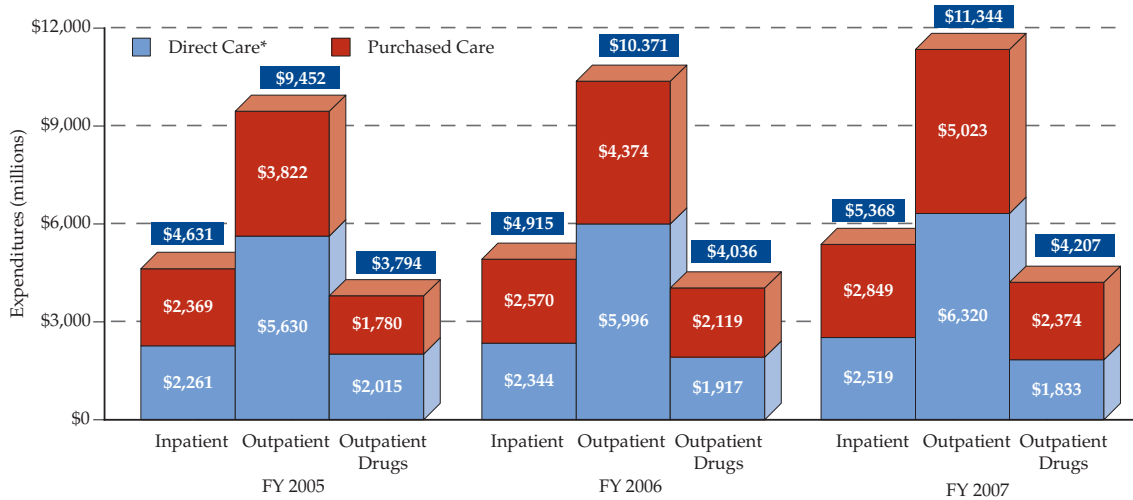
After declining in FY 2005, TMOP utilization has been steadily increasing since the middle of FY 2006. However, it is too early to tell whether this is the beginning of a long-term trend.

MHS COST TRENDS

Total MHS costs (net of TFL) increased between FY 2005 and FY 2007 for all three major components of health care services: Inpatient, outpatient, and prescription drugs. The proportion of total MHS costs accounted for by each health care service type remained about the same.

- The share of DoD expenditures on outpatient care relative to total expenditures on inpatient and outpatient care remained at about 67–68 percent from FY 2005 to FY 2007. For example, in FY 2007, DoD expenses for inpatient and outpatient care totaled \$16,711 million, of which \$11,344 million was for outpatient care for a ratio of \$11,344/\$16,711 = 68 percent.
- In FY 2007, DoD spent \$2.11 on outpatient care for every \$1 spent on inpatient care.
- The proportion of total expenses for care provided in DoD facilities fell from 55 percent in FY 2005 to 51 percent in FY 2007.

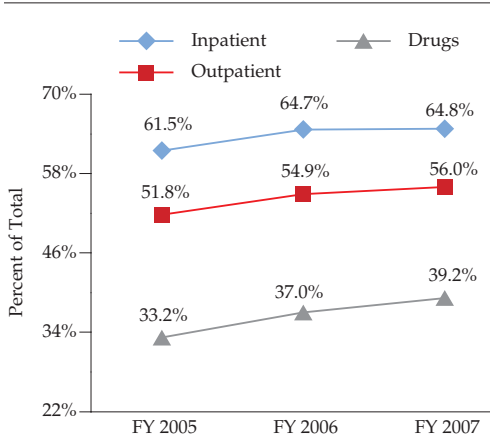
TREND IN DoD EXPENDITURES FOR HEALTH CARE (NET OF TFL)



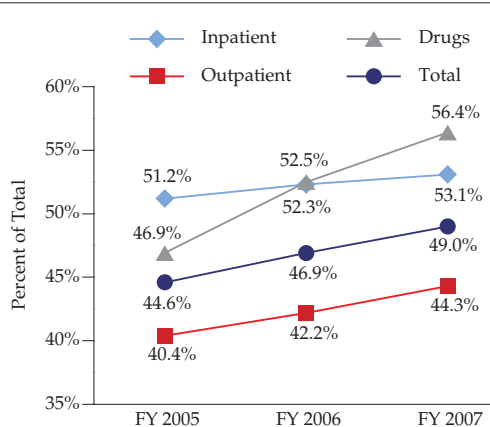
Source: MHS administrative data, 1/5/2008

* Direct care prescription costs include an MHS-derived dispensing fee.

TRENDS IN PURCHASED CARE UTILIZATION AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE



TRENDS IN PURCHASED CARE COST AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE



- The purchased care share of total inpatient utilization increased from 62 percent in FY 2005 to 65 percent in FY 2007. The purchased care share of outpatient utilization increased from 52 to 56 percent. The purchased care share of total drug utilization showed the largest increase, from 33 to 39 percent.

- The purchased care share of total MHS outpatient costs increased from 40 percent in FY 2005 to 44 percent in FY 2007. For inpatient costs, the purchased care share increased from 51 to 53 percent. Of all the medical services, prescription drugs exhibited the steepest increase in the purchased care share, from 47 to 56 percent.

Source: MHS administrative data, 1/5/2008

Note: TFL purchased care costs are excluded from the above calculations.

IMPACT OF TRICARE FOR LIFE (TFL) IN FYs 2005–2007

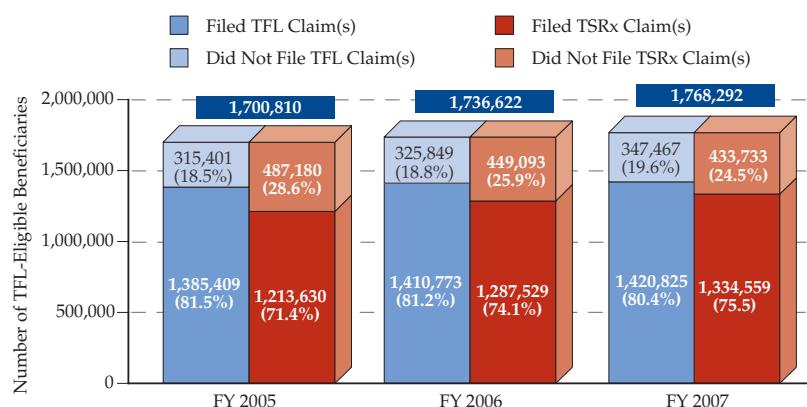
The TFL program began October 1, 2001, in accordance with the Floyd D. Spence National Defense Authorization Act for FY 2001. Under TFL, military retirees age 65 years and older, and those family members enrolled in Medicare Part B, are entitled to TRICARE coverage.

TFL and TSRx Beneficiaries Filing Claims

- The number of Medicare-eligible beneficiaries grew from 1.90 million at the end of FY 2005 to 1.97 million at the end of FY 2007.
 - The percentage eligible for TFL remained about the same from FY 2005 to FY 2007. At the end of FY 2007,

about 90 percent (1.77 million) were eligible for the TFL and TSRx benefits, whereas the remainder were ineligible for TFL either because they did not have Medicare Part B coverage or they were under age 65.

TFL-ELIGIBLE BENEFICIARIES FILING TFL AND TSRx CLAIMS IN FY 2005 TO FY 2007



Source: MHS administrative data, 1/5/2008

- The percentage of TFL-eligible beneficiaries who filed at least one claim remained about the same between FY 2005 and FY 2007.

- The reasons some beneficiaries do not file claims are varied, including retaining an employer-sponsored insurance policy (some senior beneficiaries with a spouse under age 65 will retain employer-sponsored coverage to keep their spouse insured) and not receiving any care at all.

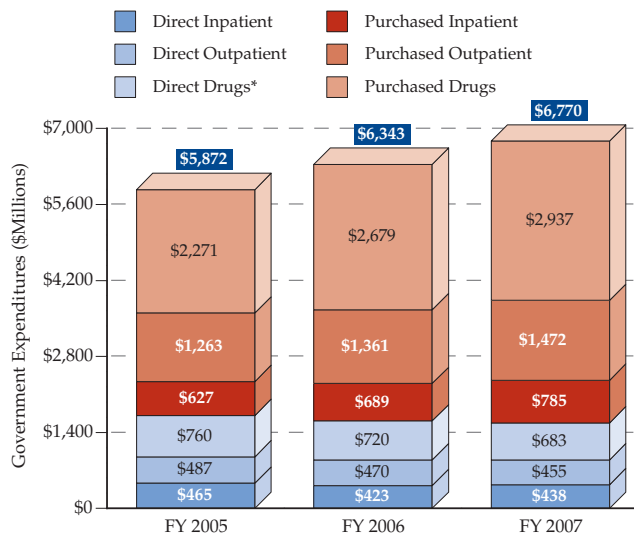
- The percentage of TFL-eligible beneficiaries who filed at least one TSRx claim increased from 71 percent in FY 2005 to 76 percent in FY 2007.

MERHCF Expenditures for Medicare-Eligible Beneficiaries

The MERHCF covers Medicare-eligible retirees, retiree family members, and survivors only, regardless of age or Part B enrollment status. The MERHCF is not identical to TFL/TSRx, which covers Medicare-eligible non-Active Duty beneficiaries age 65 and above enrolled in Part B. For example, the MERHCF covers MTF care and USFHP costs, whereas TFL and TSRx do not. Total MERHCF expenditures increased from \$5,872 million in FY 2005 to \$6,770 million in FY 2007 (15 percent).

- Total DoD direct care expenses for MERHCF-eligible beneficiaries declined by 8 percent from FY 2005 to FY 2007.

MERHCF EXPENDITURES IN FY 2005 TO FY 2007 BY TYPE OF SERVICE



Source: MHS administrative data, 1/5/2008 * Direct care prescription costs include an MHS-derived dispensing fee.

The most notable decline was in direct drug expenses (10 percent).

- From FY 2005 to FY 2007, TRICARE Plus enrollees accounted for 67–68 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries.
- Including prescription drugs, TRICARE Plus enrollees accounted for 50 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FY 2005. That percentage increased to 51 percent in FY 2007.
- Purchased care TFL expenditures increased from FY 2005 to FY 2007 for inpatient, outpatient, and prescription drugs. The most dramatic increase was for prescription drugs, where DoD costs increased by 29 percent in only two years.

IMPACT OF FY 2005 BASE REALIGNMENT AND CLOSURE (BRAC) ON PURCHASED CARE COSTS

The purpose of this study was to develop and apply a model to assess the net impact of the 2005 BRAC actions on the MHS beneficiary population and their purchased care costs, taking into account changes in direct care availability, migration, and other effects.

BACKGROUND: The 2005 BRAC is the fifth BRAC round and the largest, most complex round to date with

22 bases closed and 33 others realigned. The medical portion of the 2005 BRAC list directly affects 26 MTFs as shown in the table below. Most of the beneficiaries affected by the BRACs reside in Multi-Service Market Areas (MSMAs) where direct care services are being consolidated, such as the national capital area, San Antonio, Texas, and Colorado Springs, Colorado (column headed by “MSMA”).

BRAC 2005 LOCATIONS				
FY	MSMA	Base Location	Type of BRAC Activity	Expected Beneficiary Response
2005		Brooks City Base, San Antonio, TX	Close base, close clinic	Direct Care at BAMC and Wilford Hall
2006		MacDill AFB, FL	Downsize hospital to clinic	Migration, purchased care
2006		Ft. Eustis, VA	Downsize hospital to clinic	Migration, purchased care
2007		Scott AFB, IL	Downsize hospital to clinic	Migration, purchased care
2007		NH Great Lakes, IL	Downsize hospital to clinic, merge with VA	Migration, purchased care
2007		Selfridge AHC, MI	Close base, close clinic	Migration, purchased care
2007		NBHC Pascagoula, MS	Close base, close clinic	Direct Care at Keesler AFB
2008	Yes	Air Force Academy, CO	Downsize hospital to clinic	Inpatient care at Ft. Carson
2008		NH Cherry Point, NC	Downsize hospital to clinic	Migration, purchased care
2009	Yes	Malcolm Grow AFMC, Andrews AFB, MD	Downsize medical center to clinic with same day surgery	Inpatient care elsewhere in national capital area
2010		BMC Barstow, CA	Realign base, close clinic	Migration, purchased care
2010		BMC Marietta, GA	Close base, close clinic	Migration, purchased care
2010		BMC Ingleside, TX	Close base, close clinic	Direct Care at Corpus Christie Naval Hospital
2010		BMC NSA, New Orleans, LA	Realign base, close clinic	Direct Care at NBHC NAS Belle Chase
2011	Yes	Walter Reed Army Medical Center (WRAMC), DC	Close medical center, assets move to Walter Reed National Medical Center (WRNMC)	Utilization and enrollment move to Ft. Belvoir WRNMC and Belvoir
2011	Yes	Bethesda Naval Medical Center, MD	Renamed as Walter Reed National Medical Center	Increased utilization and enrollment Center (WRNMC)
2011		Patterson AHC, Ft. Monmouth NJ	Close base, close clinic	Migration, purchased care
2011	Yes	Brooke Army Medical Center, TX	Renamed as San Antonio Regional Medical	Increased utilization and enrollment Center (SARMC)
2011	Yes	Wilford Hall AFMC, Lackland AFB, TX	Downsize medical center to clinic with same	Decreased utilization and enrollment day surgery
2011	Yes	Ft. Belvoir, VA	Expand hospital	Increased utilization and enrollment
2011		AHC Ft. McPherson, GA	Close base, close clinic	Migration, purchased care
2011		BMC Athens, GA	Close base, close clinic	Migration, purchased care
2011		BMC NAS Brunswick, ME	Close base, close clinic	Migration, purchased care
2011		BMC Willow Grove, Hatboro, PA	Close base, close clinic	Migration, purchased care
2011		Monroe AHC, Ft. Monroe, VA	Close base, close clinic	Migration, purchased care
Unknown		Keesler AFB, MS	Downsize medical center to community hospital	Reduced referrals for subspecialty care

FINDINGS: As expected, this study forecasts purchased care costs will increase following MTF closures and downsizing by \$89 million in FY 2007, and reaching \$275 million in 2013 (as shown in the chart below, costs are in constant FY 2006 dollars). Controlling for the effects of force structure, demographic changes, and inflation, the singular effect of

the FY 2005 BRAC on annual (noncumulative) purchased care costs in constant FY 2006 dollars is projected to result in a net cost of \$154 million in 2013. Constant year FY 2006 dollar projections are based on the official DoD Comptroller’s estimate of 7 percent per year inflation for purchased care.

Fiscal Year	2007	2008	2009	2010	2011	2012	2013
Purchased Care Cost Increase Due to BRAC (FY 2006 \$M)	\$89	\$138	\$207	\$211	\$248	\$272	\$275
Direct Care Savings (FY 2006 \$M)	\$12	\$17	\$72	\$75	\$126	\$118	\$122
Net Cost to DHP (FY 2006 \$M)	\$78	\$121	\$135	\$136	\$123	\$154	\$154

However, across the entire Defense Health Program, overall purchased health care costs in constant FY 2006 dollars are expected to remain the same at about \$13.57 billion. There are several factors that will affect purchased care costs between FY 2006 and FY 2013, including force structure, beneficiary demographics, inflation, and direct care availability. Force structure is currently projected to remain high through FY 2009 and then fall between FY 2010 and FY 2013, resulting

in a reduction of 334,000 Active Duty and ADFMs. Retiring baby boomers are expected to swell the number of retirees and retiree family members by 137,000. The effects on purchased care costs of projected force structure reductions, beneficiary demographics, and BRAC realignments tend to offset each other between FY 2006 and FY 2013. The largest factor affecting the growth of purchased care costs continues to be the medical inflation rate.

COMBINED INPATIENT & OUTPATIENT MARKET SHARE

As a measure of enrollment market share, the inpatient workload for TRICARE Prime enrollees accomplished in MTFs relative to all Prime workload in catchment areas¹ (a radius of 40 miles for hospitals and 20 miles for ambulatory care facilities) has declined over the past three years. From FY 2005 to FY 2007, MTF inpatient workload market share declined by more than 2 percentage points.

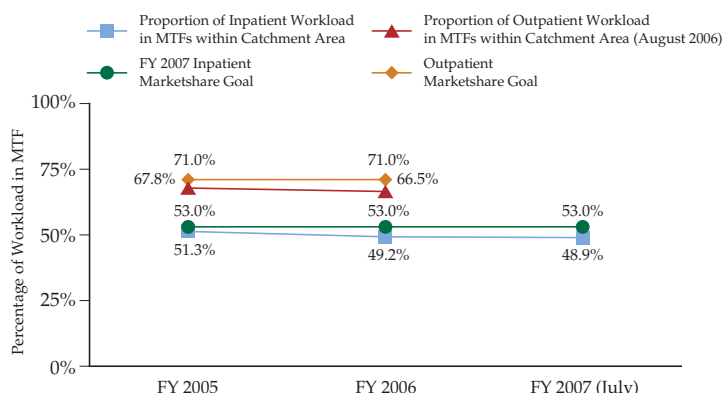
No adjustments have been made to account for the effects of deploying military providers and support staff, nor for the significant influx of National Guard and Reservists mobilized since September 11, 2001, and their family members, who have become eligible for the TRICARE benefit.

Source: MHS administrative data reported in the Annual Defense Review, 11/30/2007

Note: Market share measures exclude TFL workload from purchased care. Inpatient workload is based on RWPs, and outpatient workload is based on visits. Inpatient workload is based on 40-mile catchment area; outpatient workload is based on catchment areas for stand-alone clinics and 20-mile catchment area surrounding the "Parent" MTF with inpatient services.

¹ As noted on page 22, the catchment area concept is being replaced within the MHS by MTF enrollment areas.

PERCENTAGE OF ENROLLEE WORKLOAD PERFORMED BY MTFs IN CATCHMENT AREAS



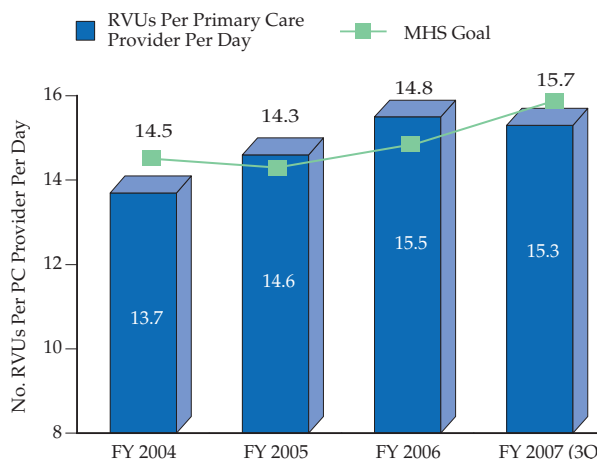
SYSTEM PRODUCTIVITY - RVU PER FULL TIME EQUIVALENT

The purpose of this metric is to focus on the productivity of the direct care system at the provider level. Performance is measured as the number of RVU encounters (visits) per full-time equivalent (FTE) primary care provider in U.S. military clinics.

MHS productivity increased in FY 2006 to 15.3 RVUs per primary care provider per day in FY 2007, compared to 15.5 in FY 2006 and 14.6 in FY 2005 (however, missing data at time of writing may result in overstating performance). Similar to the market share analysis above, no adjustments in actual productivity have been made to account for the effects of deploying military providers and support staff, nor for the influx of mobilized National Guard and Reservists and their family members.

Source: MHS administrative data reported in the Annual Defense Review, 11/30/2007. Measure is defined as the number of RVUs per FTE provider per 8-hour day in U.S. military clinics.

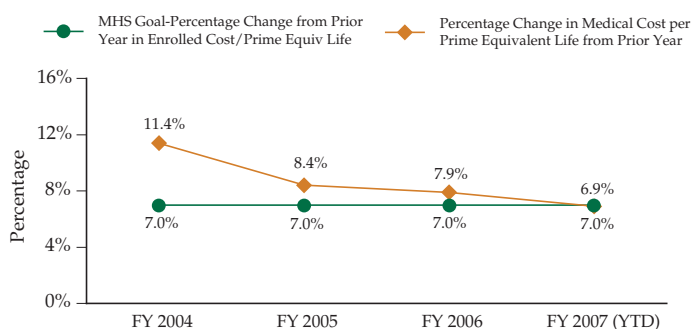
MTF PRIMARY CARE PROVIDER PRODUCTIVITY (RVUs/PROVIDER/DAY)



MEDICAL COST PER PRIME ENROLLEE

The goal of this financial and productivity metric in FY 2007 is to stay below a 7 percent annual rate of increase, based on the projected rise in private health insurance premiums. The annual rate of increase in average medical costs per Prime enrollee has declined from a high of 11 percent in FY 2004 to 7 percent in FY 2007 (through the third fiscal quarter).

PERCENTAGE CHANGE IN MEDICAL COST PER PRIME EQUIVALENT LIFE (FROM PRIOR YEAR)



Source: MHS administrative data reported in the Annual Defense Review, 11/30/2007. Enrollees counts are not adjusted for age and gender.

INPATIENT UTILIZATION RATES AND COSTS

TRICARE Prime Inpatient Utilization Rates Compared with Civilian Benchmarks

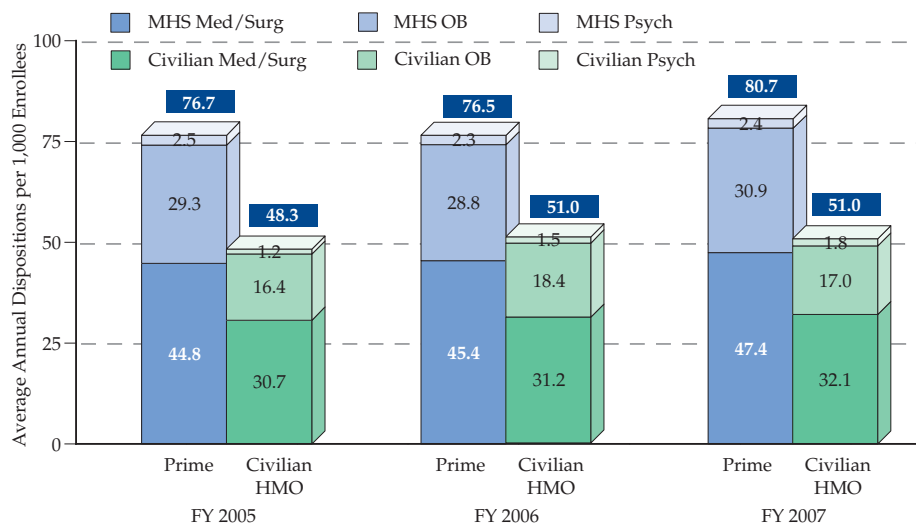
TRICARE Prime Enrollees

This section compares the inpatient utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored health maintenance organization (HMO) plans. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and purchased care dispositions) because RWP are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—OB/GYN, mental health (PSYCH), and other MED/SURG—and compared for *acute care facilities only*. The comparisons exclude beneficiaries age 65 and older because very few are covered by employer-sponsored plans. The MHS data further exclude beneficiaries enrolled in the USFHP and TRICARE Plus.

- The TRICARE Prime inpatient utilization rate (direct and purchased care combined) was 58 percent higher than the civilian HMO utilization rate in FY 2007 (80.7 discharges per thousand Prime enrollees compared with 51.0 per 1,000 civilian HMO enrollees). This ratio has not changed much in the past three years.
- In FY 2007, the TRICARE Prime inpatient utilization rate was 48 percent higher than the civilian HMO rate for MED/SURG procedures, 81 percent higher for OB/GYN procedures, and 32 percent higher for PSYCH procedures. The latter ratio, though based on relatively low MHS and civilian disposition rates, likely reflects the more stressful environment that many Active Duty Service Members and their families endure.

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data and Thomson Healthcare Inc., MarketScan® Commercial Claims and Encounters database, 1/5/2008

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2007 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

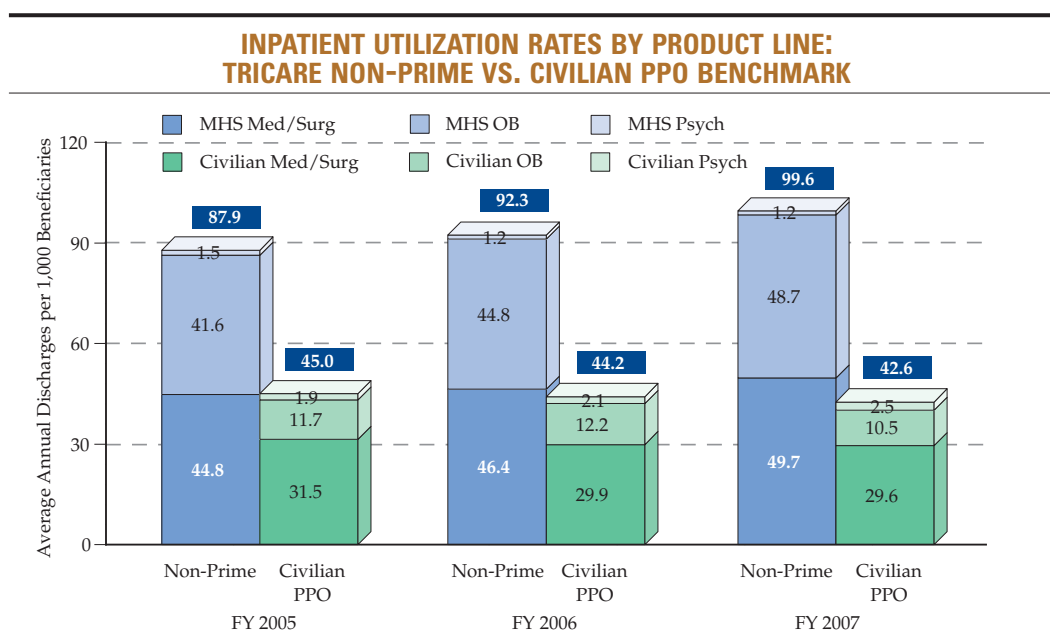
INPATIENT UTILIZATION RATES AND COSTS (CONT'D)

Non-Enrolled Beneficiaries

This section compares the inpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored preferred provider organization (PPO) plans. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and purchased care dispositions) because RWP are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG procedures—and compared for acute care facilities only. The comparisons exclude beneficiaries age 65 and older because very few are covered by employer-sponsored plans. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate between 7 and 10 percent (depending on the year) do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include them.

- The inpatient utilization rate (direct and purchased care combined) for non-enrolled beneficiaries was more than double the rate for civilian PPO participants. From FY 2005 to FY 2007, the inpatient utilization rate for non-enrolled beneficiaries was increasing at the same time it was decreasing in the civilian sector.
- By far the largest discrepancy in utilization rates between the MHS and private sector is for OB/GYN procedures. In FY 2007, the MHS OB disposition rate was more than four times higher than the corresponding civilian rate.



Sources: MHS administrative data and Thomson Healthcare Inc., MarketScan® Commercial Claims and Encounters database, 1/5/2008

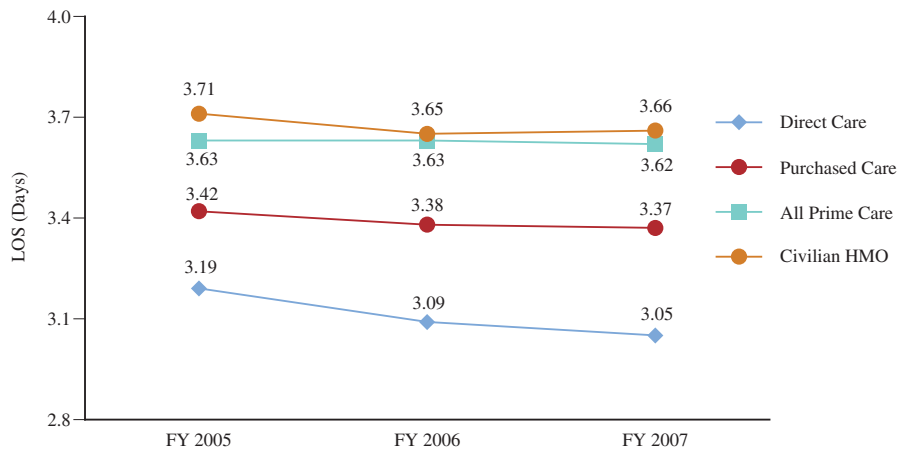
Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2007 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

INPATIENT UTILIZATION RATES AND COSTS (CONT'D)

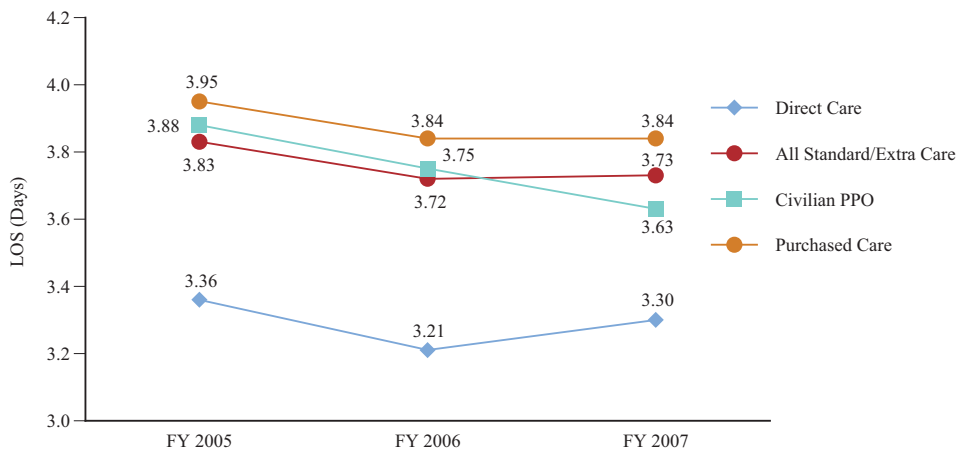
Average Lengths of Stay in Acute Care Hospitals

- Average lengths of stay (LOS) for Prime enrollees in DoD facilities (direct care) declined slightly between FY 2005 and FY 2007. After declining in FY 2006, average LOS for space-available care increased in FY 2007 to slightly under its FY 2005 level. Purchased care LOS remained the same for Prime enrollees and declined slightly for non-enrolled beneficiaries.
- Average LOS in TRICARE purchased acute care facilities are well above those in DoD facilities. Hospital stays in purchased care facilities are longer on average than in DoD facilities because purchased care facilities perform more complex procedures (as determined by RWPs—a measure of inpatient resource intensity).
- Average LOS for MHS-wide Prime and Standard/Extra care have followed roughly the same trends as their civilian HMO and PPO counterparts, respectively.
- In FY 2007, average LOS for MHS-wide Prime care was 8 percent lower than in civilian HMOs. The average LOS for non-Prime care (space-available and Standard/Extra) was 3 percent higher than in civilian PPOs.

INPATIENT AVERAGE LENGTH OF STAY: TRICARE PRIME vs. CIVILIAN HMO



INPATIENT AVERAGE LENGTH OF STAY: TRICARE STANDARD/EXTRA vs. CIVILIAN PPO



Sources: MHS administrative data and Thomson Healthcare Inc., MarketScan® Commercial Claims and Encounters database, 1/5/2008

Note: Beneficiaries age 65 and older were excluded from the above calculations. Further, the civilian data for each year were adjusted to reflect the age/sex distribution of MHS inpatient dispositions (civilian HMO data were adjusted by Prime dispositions and civilian PPO data were adjusted by Standard/Extra dispositions). FY 2007 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

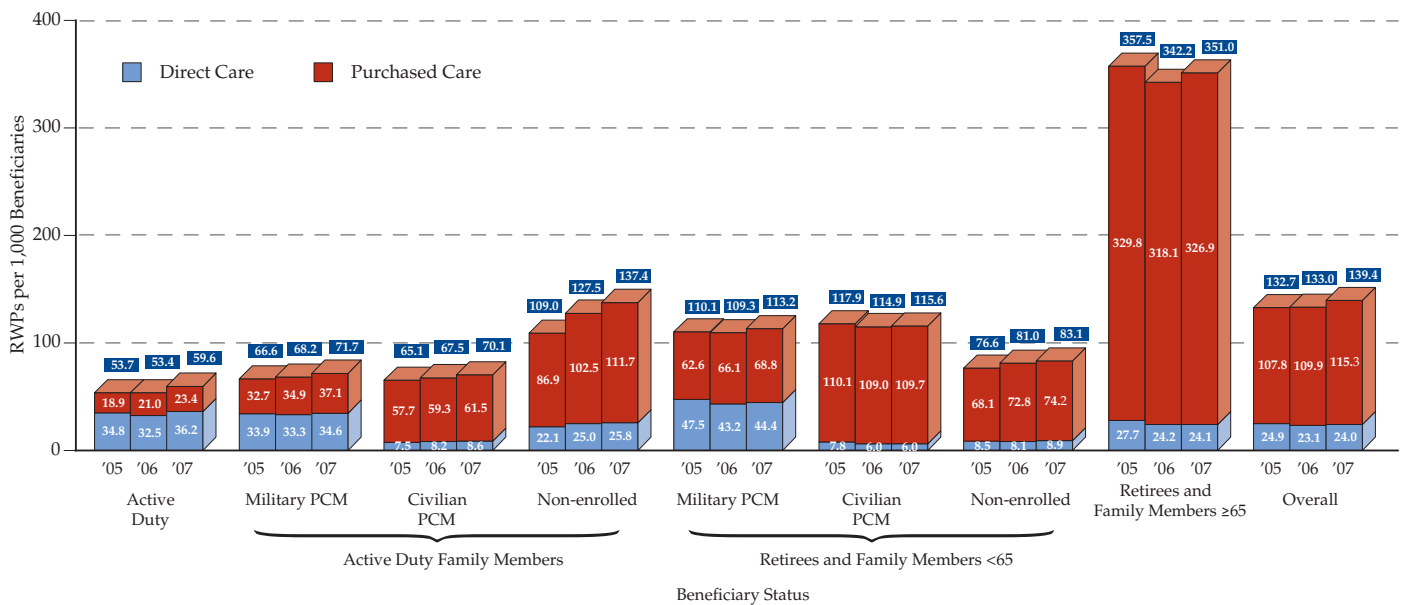
INPATIENT UTILIZATION RATES AND COSTS (CONT'D)

Inpatient Utilization Rates by Beneficiary Status

When breaking out inpatient utilization by beneficiary group, RWP's per capita should more accurately reflect differences across beneficiary groups than discharges per capita. However, RWP's are relevant only for acute care hospitals.

- The direct care inpatient utilization rate (RWP's per 1,000 beneficiaries) increased the most (16 percent) for nonenrolled ADFMs and decreased the most (23 percent) for retirees and family members under age 65 with a civilian PCM.
- Purchased acute care inpatient utilization rates increased for all beneficiary groups except retirees and family members under 65 with a civilian PCM and seniors, for whom they remained the same.
- The TFL acute care inpatient utilization rate declined by 2 percent between FY 2005 and FY 2007.*
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE has become second payer to Medicare), the percentage of total inpatient workload performed in purchased care facilities remained essentially unchanged at about 70 percent.
- From FY 2005 to FY 2007, the percentage of inpatient workload (RWP's) referred to the network on behalf of beneficiaries enrolled with a military PCM (including Active Duty personnel) increased from 47 percent to 51 percent.

AVERAGE ANNUAL INPATIENT RWP's PER 1,000 BENEFICIARIES (BY FISCAL YEAR)



Source: MHS administrative data, 1/5/2008

* The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there are a small number of beneficiaries age 65 and older who are not eligible for TFL and an even smaller number of beneficiaries under age 65 who are eligible.

INPATIENT UTILIZATION RATES AND COSTS (CONT'D)

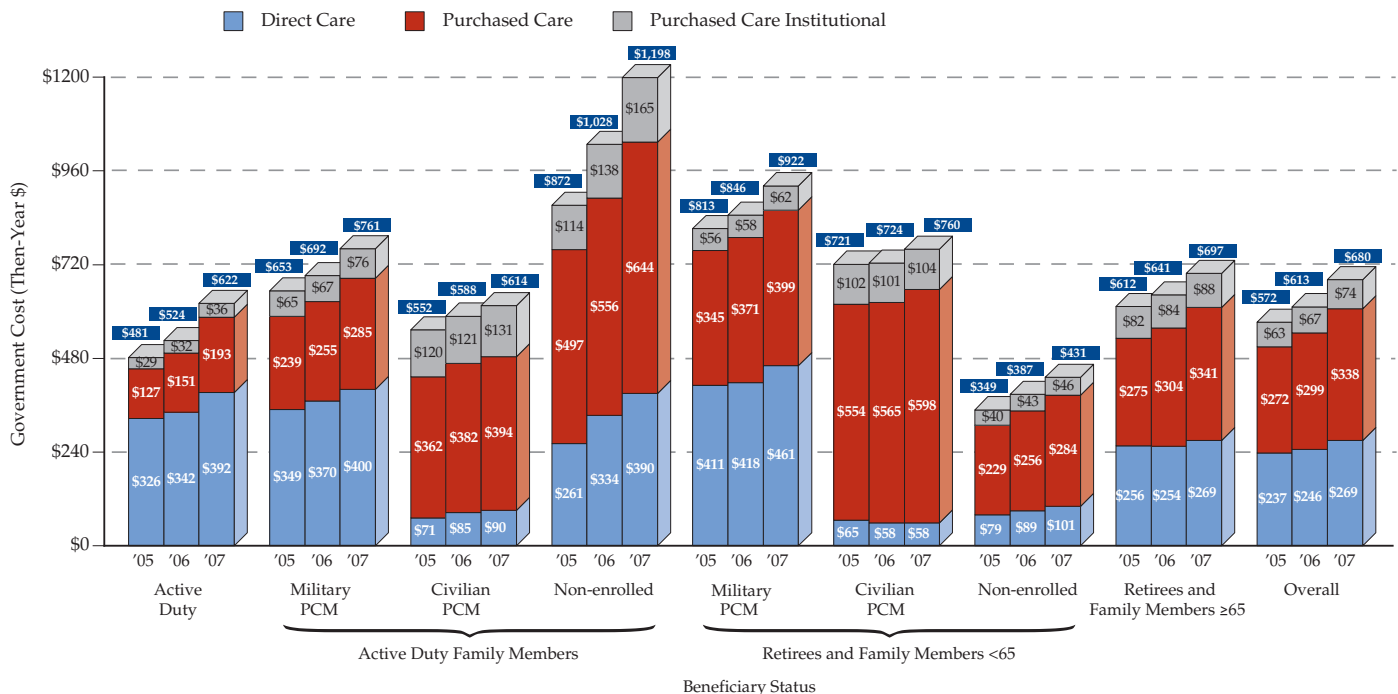
Inpatient Cost by Beneficiary Status

MHS costs for inpatient care include costs incurred in both acute and non-acute care facilities. They also include the cost of inpatient professional services, i.e., noninstitutional charges (e.g., physician, lab, anesthesia) associated with a hospital stay. Overall MHS inpatient costs (in then-year dollars) per beneficiary (far right columns below) increased by 7 percent in FY 2006 and by another 11 percent in FY 2007. The increases were due largely to higher purchased care costs.

- The direct care cost per RWP increased from \$9,489 in FY 2005 to \$11,178 in FY 2007 (18 percent).
- Exclusive of TFL, the purchased care cost per RWP increased from \$6,164 in FY 2005 to \$6,722 in FY 2007 (9 percent). The purchased care cost per RWP is much

lower than that for direct care because many beneficiaries using purchased care have other health insurance. When beneficiaries have other health insurance, TRICARE becomes second payer and the Government pays a smaller share of the cost.

AVERAGE ANNUAL DoD INPATIENT COST PER BENEFICIARY (BY FISCAL YEAR)



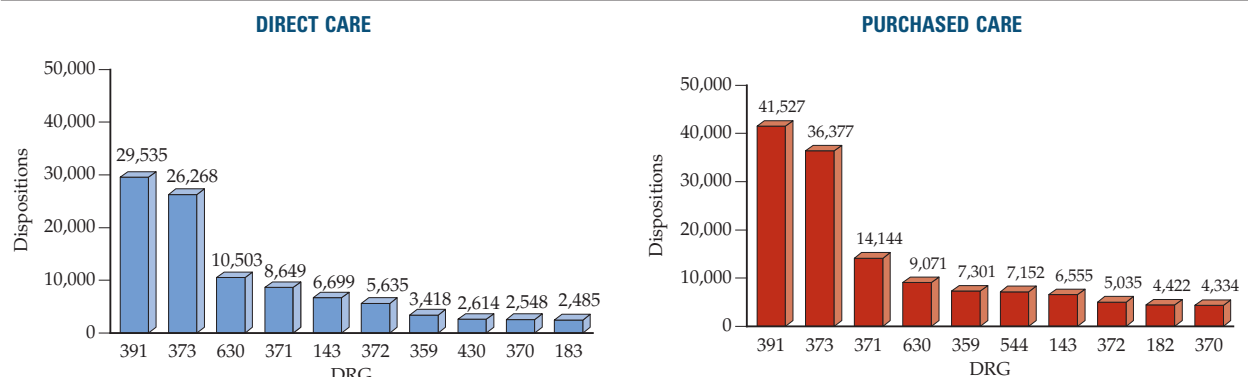
Source: MHS administrative data, 1/5/2008

INPATIENT UTILIZATION RATES AND COSTS (CONT'D)

Leading Inpatient Diagnoses by Volume

The top 10 diagnosis-related groups (DRGs) in terms of admissions in FY 2007 accounted for 42 percent of all inpatient admissions in military hospitals (direct care) and for 39 percent in civilian acute care hospitals (purchased care). TFL admissions are excluded.

TOP 10 DIRECT CARE AND PURCHASED CARE DRGs IN FY 2007 BY VOLUME



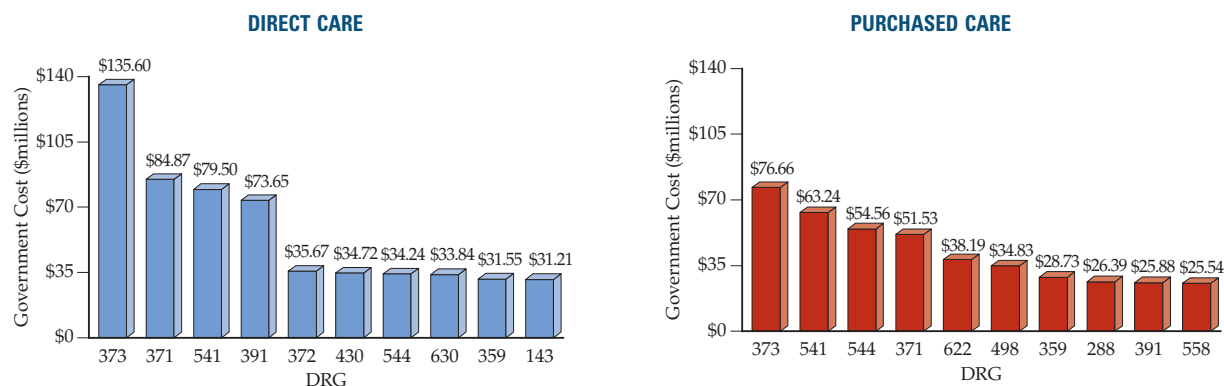
- 143 Chest pain
- 182 Esophagitis, gastroent, and misc digest disorders age >17 with Complications and Comorbidities
- 183 Esophagitis, gastroent, and misc digest disorders age >17 without CC
- 359 Uterine and adnexa proc for nonmalignancy without CC
- 370 Cesarean section with CC
- 371 Cesarean section without CC

- 372 Vaginal delivery with complicating diagnoses
- 373 Vaginal delivery without complicating diagnoses
- 391 Normal newborn
- 430 Psychoses
- 544 Major joint replacement or reattachment of lower extremity
- 630 Neonate, birthwt >2499G, without signif or proc, with other prob

Leading Inpatient Diagnoses by Cost

The leading diagnoses in terms of cost in FY 2007 were determined from institutional claims only; i.e., they include hospital charges but not attendant physician, laboratory, drug, or ancillary service charges. The top 10 DRGs in terms of cost in FY 2007 accounted for 25 percent of total direct care inpatient costs and for 23 percent of total purchased care costs in civilian acute care hospitals. TFL admissions are excluded.

TOP 10 DIRECT CARE AND PURCHASED CARE DRGs IN FY 2007 BY COST



- 143 Chest Pain
- 288 O.R. Procedures for obesity
- 359 Uterine and adnexa proc for nonmalignancy without CC
- 371 Cesarean section without CC
- 372 Vaginal delivery with complicating diagnoses
- 373 Vaginal delivery without complicating diagnoses
- 391 Normal newborn
- 430 Psychoses
- 498 Spinal fusion except cervical w/o CC

- 541 Ecmo or trach with mv 96+hrs or pdx exc fce, mouth & nck with maj O.R.
- 544 Major joint replacement or reattachment of lower extremity
- 558 Percutaneous cardiovasc proc with drug-eluting stent without maj cv dx
- 622 Neonate, birthwt >2499G, with signif or proc, with mult major prob
- 630 Neonate, birthwt >2499G, without signif or proc, with other prob

Source: MHS administrative data, 1/5/2008

OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks

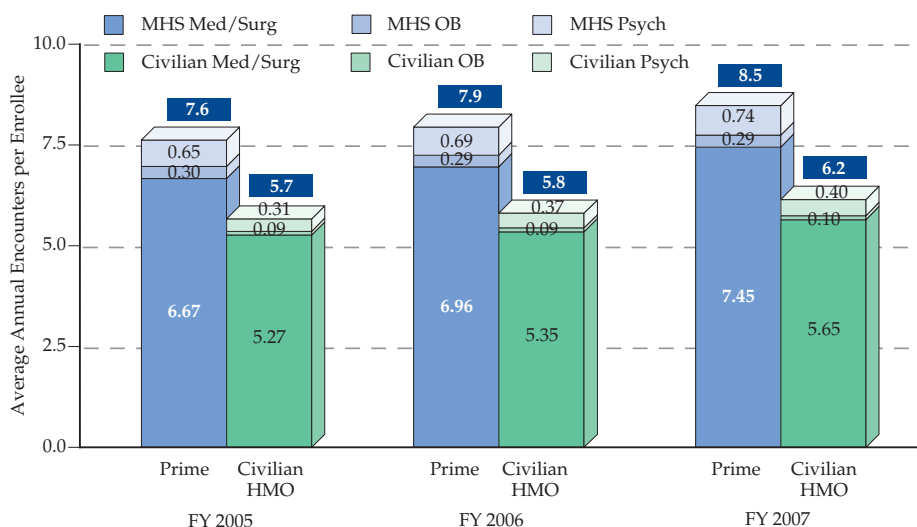
TRICARE Prime Enrollees

This section compares the outpatient utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored HMO plans. Outpatient utilization is measured as the number of encounters because the civilian-sector data do not contain a measure of RVUs.

Encounters are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG procedures. The comparisons are made for beneficiaries under age 65 only. The MHS data exclude beneficiaries enrolled in the USFHP and TRICARE Plus. Because telephone consults are routinely recorded in direct care data, but appear very infrequently in private-sector claims, they are also excluded from the direct care utilization computations.

- The overall TRICARE Prime outpatient utilization rate (direct and purchased care utilization) 64 encounters per enrollee in FY 2005 to 8.5 in FY 2007. The civilian HMO outpatient utilization rate rose by 8 percent over the same time period.
- In FY 2007, the overall Prime outpatient utilization rate was 39 percent higher than the civilian HMO rate.
- In FY 2007, the Prime outpatient utilization rate for MED/SURG procedures was 32 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures was almost triple the corresponding rate for civilian HMOs, but that is due in part to how the direct care system records bundled services.^a
- The Prime outpatient utilization rate for PSYCH procedures was almost double the corresponding rate for civilian HMOs. This disparity, though based on relatively low MHS and civilian mental health utilization rates, may reflect the more stressful environment that many Active Duty Service Members and their families endure.

OUTPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data and Thomson Healthcare Inc., MarketScan® Commercial Claims and Encounters database, 1/5/2008

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2007 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

^aOutpatient encounters are not precisely comparable between the direct and private care sectors (including purchased care). In particular, services that are bundled in the private sector (such as newborn delivery, including pre-natal and post-natal care) will not generate any outpatient encounters but will generate a record for each encounter in the direct care system. Because maternity care is a high-volume procedure, the disparity in utilization rates between the direct care and civilian systems will be exacerbated.

OUTPATIENT UTILIZATION RATES AND COSTS (CONT'D)

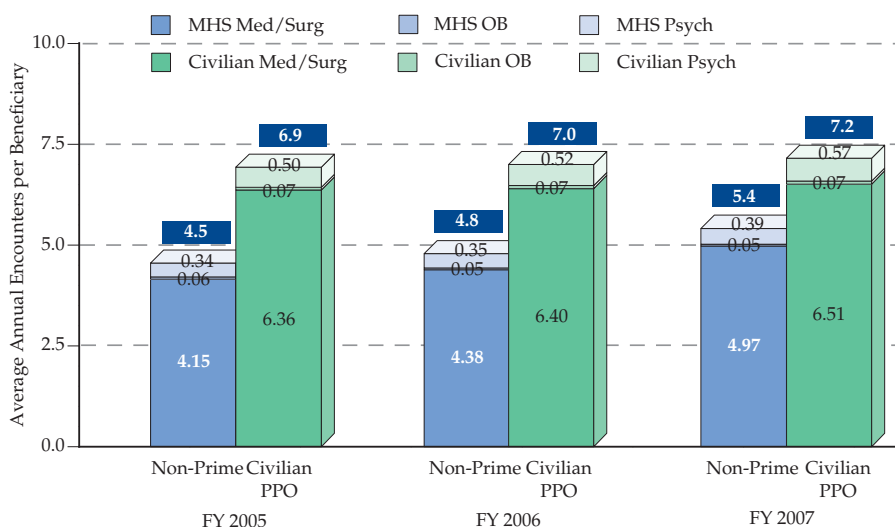
Non-Enrolled Beneficiaries

This section compares the outpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. Outpatient utilization is measured as the number of encounters because the civilian-sector data do not contain a measure of RVUs.

Encounters are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG. The comparisons are made for beneficiaries under age 65 only. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Because telephone consults are routinely recorded in direct care data, but appear very infrequently in private-sector claims, they are also excluded from the direct care utilization computations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate between 7 and 10 percent (depending on the year) do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include them.

- The overall TRICARE outpatient utilization rate (direct and purchased care utilization combined) for non-enrolled beneficiaries increased by 19 percent from 4.8 encounters per participant in FY 2005 to 5.6 in FY 2007. The civilian PPO outpatient utilization rate increased by only 3 percent over this period.
- The overall TRICARE non-Prime (space-available and Standard/Extra) outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2007, TRICARE non-Prime outpatient utilization was 24 percent lower than in civilian PPOs.
- Medical/surgical procedures account for about 92 percent of total outpatient utilization in both the military and private sectors.
- The non-Prime outpatient utilization rates for OB/GYN procedures held steady between FY 2005 and FY 2007 at about the same level as those for civilian PPO participants.
- The PSYCH outpatient utilization rates of both non-enrolled MHS beneficiaries and civilian PPO participants increased by about 15 percent from FY 2005 to FY 2007. Even so, the PSYCH outpatient utilization rate for non-enrolled beneficiaries was 32 percent below that of civilian PPO participants in FY 2007. The latter observation, together with the utilization exhibited by Prime enrollees, suggests that MHS beneficiaries in need of extensive PSYCH counseling are more likely to enroll in Prime.

**OUTPATIENT UTILIZATION RATES BY PRODUCT LINE:
TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK**



Sources: MHS administrative data and Thomson Healthcare Inc., MarketScan® Commercial Claims and Encounters database, 1/5/2008

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2007 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

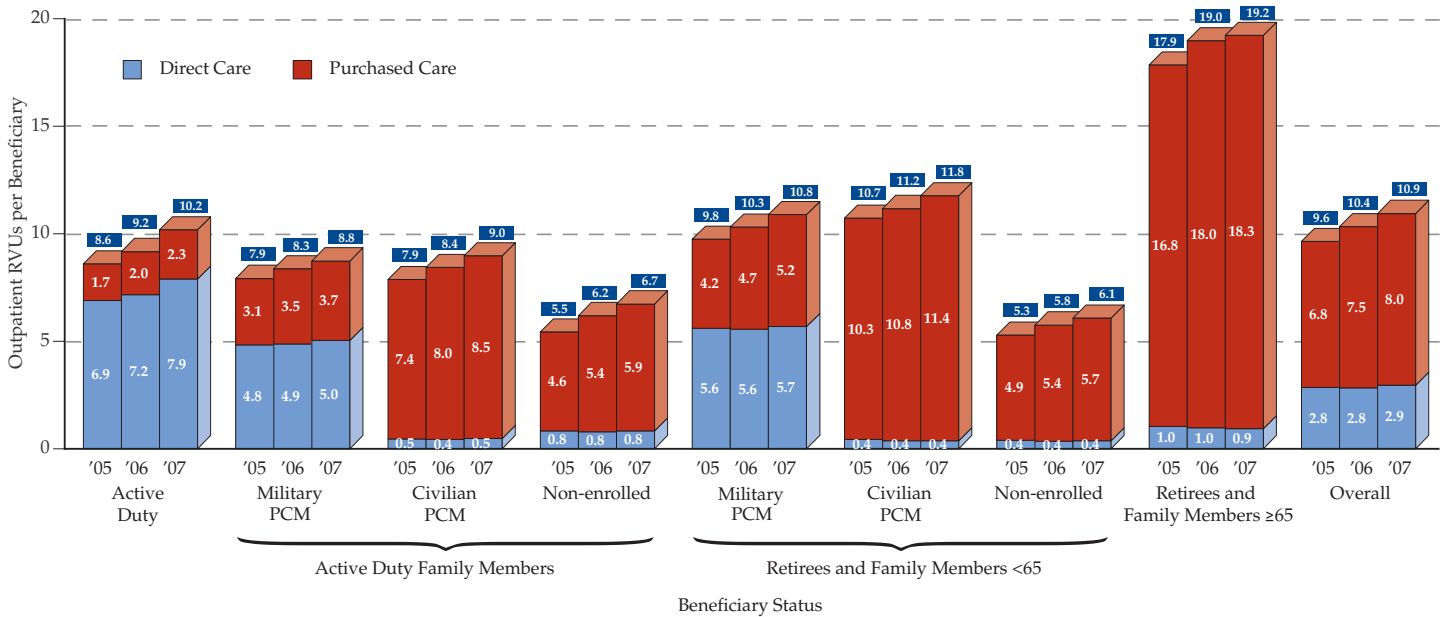
OUTPATIENT UTILIZATION RATES AND COSTS (CONT'D)

Outpatient Utilization Rates by Beneficiary Status

When breaking out outpatient utilization by beneficiary group, RVUs per capita should more accurately reflect differences across beneficiary groups than encounters per capita.

- The direct care outpatient utilization rate increased by 15 percent from FY 2005 to FY 2007 for Active Duty personnel. The rate increased slightly for ADFMs and retirees with a military PCM, and declined for all other beneficiary groups. Retirees and family members with a civilian PCM and seniors experienced the largest declines.
- From FY 2005 to FY 2007, the purchased care outpatient utilization rate increased significantly for all beneficiary groups. The largest increase (32 percent) was experienced by Active Duty personnel.
- After rising by 6 percent in FY 2006, the TFL outpatient utilization rate increased by only 1 percent in FY 2007.*

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 1/5/2008

* The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there are a small number of beneficiaries age 65 and older who are not eligible for TFL and an even smaller number of beneficiaries under age 65 who are eligible.

Note: The Centers for Medicare and Medicaid Services (CMS) recently completed a quintennial study of payment policies for professional services that resulted in a "re-baselining" of RVUs. Consequently, part of any observed changes in FY 2007 RVUs are artificial and can be attributed directly to the change in weights and not necessarily volume or complexity of services. FY 2007 RVUs were therefore adjusted to reflect the FY 2006 RVU weights.

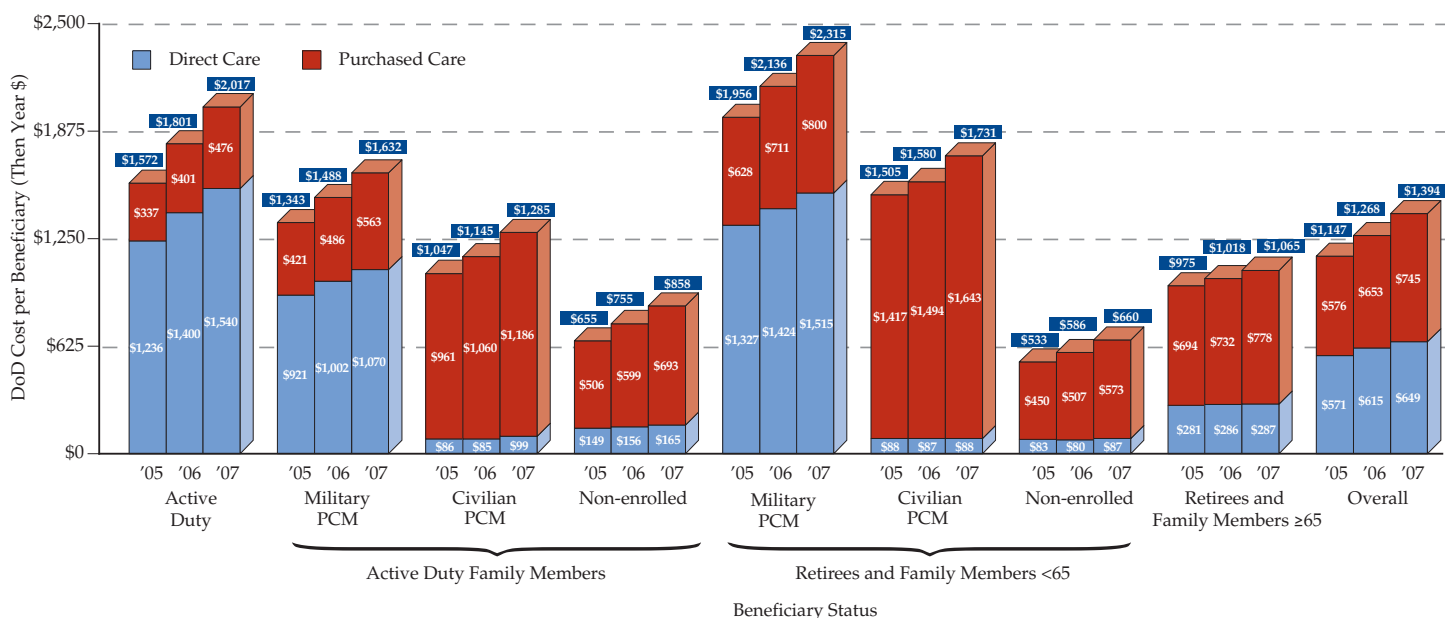
OUTPATIENT UTILIZATION RATES AND COSTS (CONT'D)

Outpatient Cost by Beneficiary Status

Corresponding to higher purchased care outpatient utilization rates, DoD medical costs continued to rise. Overall, DoD outpatient costs per beneficiary increased by 22 percent from FY 2005 to FY 2007.

- The direct care cost per beneficiary increased for all MTF-enrolled beneficiaries, particularly Active Duty personnel (25 percent increase).
- Net of TFL, the DoD purchased care outpatient cost per beneficiary increased by 16 percent in FY 2006 and again in FY 2007. Thus, the recent trend in double-digit purchased care cost increases unabated.
- The TFL purchased care outpatient cost per beneficiary increased by only 4 percent in both FYs 2006 and 2007, mostly due to minimal direct care cost increases.*

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 1/5/2008

* The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there are a small number of beneficiaries age 65 and older who are not eligible for TFL and an even smaller number of beneficiaries under age 65 who are eligible.

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks

Prescription utilization is difficult to quantify since prescriptions come in different forms (e.g., liquid or pills), quantities, and dosages. Moreover, TMOP and MTF prescriptions can be filled for up to a 90-day supply, whereas retail prescriptions are usually based on 30-day increments for copay purposes. Prescription counts from all sources (including civilian) were normalized by dividing the total days supply for each by 30 days.

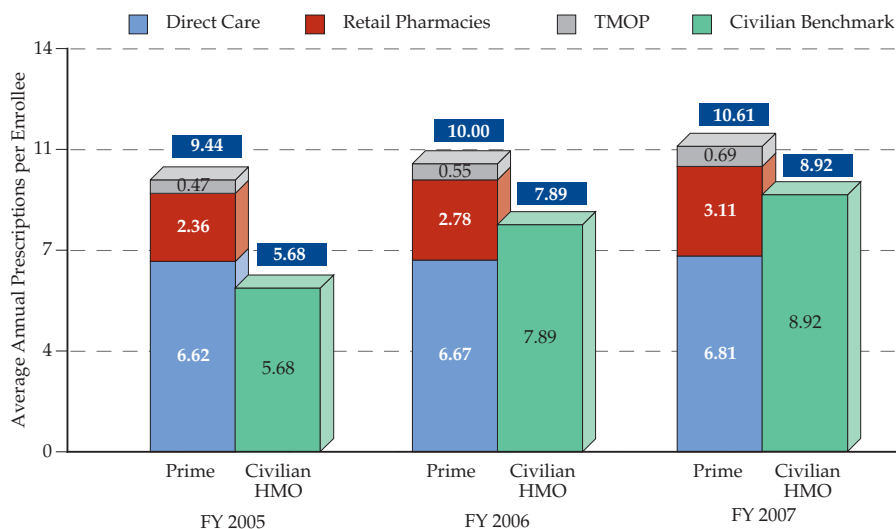
Direct care pharmacy data differ from private sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the DoD Pharmacoeconomic Center.

TRICARE Prime Enrollees

This section compares the prescription drug utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored HMO plans. The comparisons are made for beneficiaries under age 65 only. The MHS data exclude beneficiaries enrolled in the USFHP and TRICARE Plus.

- The overall prescription utilization rate (direct and purchased care combined) for TRICARE Prime enrollees rose by 12 percent between FY 2005 and FY 2007. Although the civilian HMO benchmark rate rose by 18 percent over this period, the TRICARE Prime prescription utilization rate was still 19 percent higher than the civilian HMO rate in FY 2007.
- Prescription utilization rates for Prime enrollees at DoD pharmacies increased by 3 percent, whereas the utilization rate at retail pharmacies increased by 32 percent from FY 2005 to FY 2007.
- Enrollee mail order prescription utilization increased by 48 percent from FY 2005 to FY 2007. Nevertheless, TMOP utilization remains small compared to other sources of prescription services.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE*: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data and Thomson Healthcare Inc., MarketScan® Commercial Claims and Encounters database, 1/5/2008

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2007 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

*Source of care (direct or purchased) is based solely on where care is received, not where beneficiaries are enrolled.

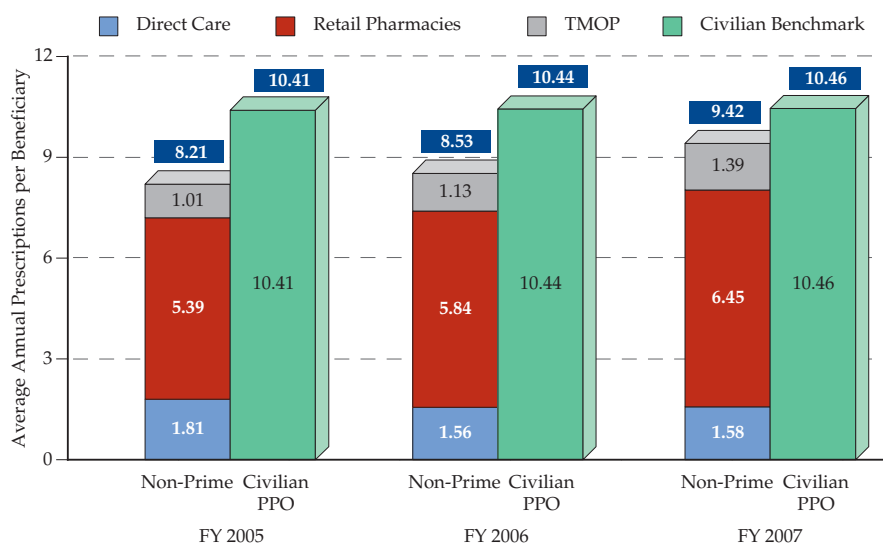
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS (CONT'D)

Non-Enrolled Beneficiaries

This section compares the prescription drug utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. The comparisons are made for beneficiaries under age 65 only. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate between 7 and 10 percent (depending on the year) do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include them.

- The overall prescription utilization rate (direct and purchased care combined) for non-enrolled beneficiaries rose by 15 percent between FY 2005 and FY 2007. During the same period, the civilian PPO benchmark rate remained constant. Although the gap has significantly narrowed, the TRICARE prescription utilization rate is still 10 percent lower than the civilian PPO rate.
- Prescriptions filled for non-enrolled beneficiaries at DoD pharmacies dropped by 12 percent, whereas prescriptions filled at retail pharmacies increased by 20 percent from FY 2005 to FY 2007.
- Non-enrollee mail order prescription utilization increased by 37 percent from FY 2005 to FY 2007. Nevertheless, TMOP utilization remains small compared to other sources of prescription services.

**PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE*:
TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK**



Sources: MHS administrative data and Thomson Healthcare Inc., MarketScan® Commercial Claims and Encounters database, 1/5/2008

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2007 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

* Source of care (direct or purchased) is based solely on where care is received, not where beneficiaries are enrolled.

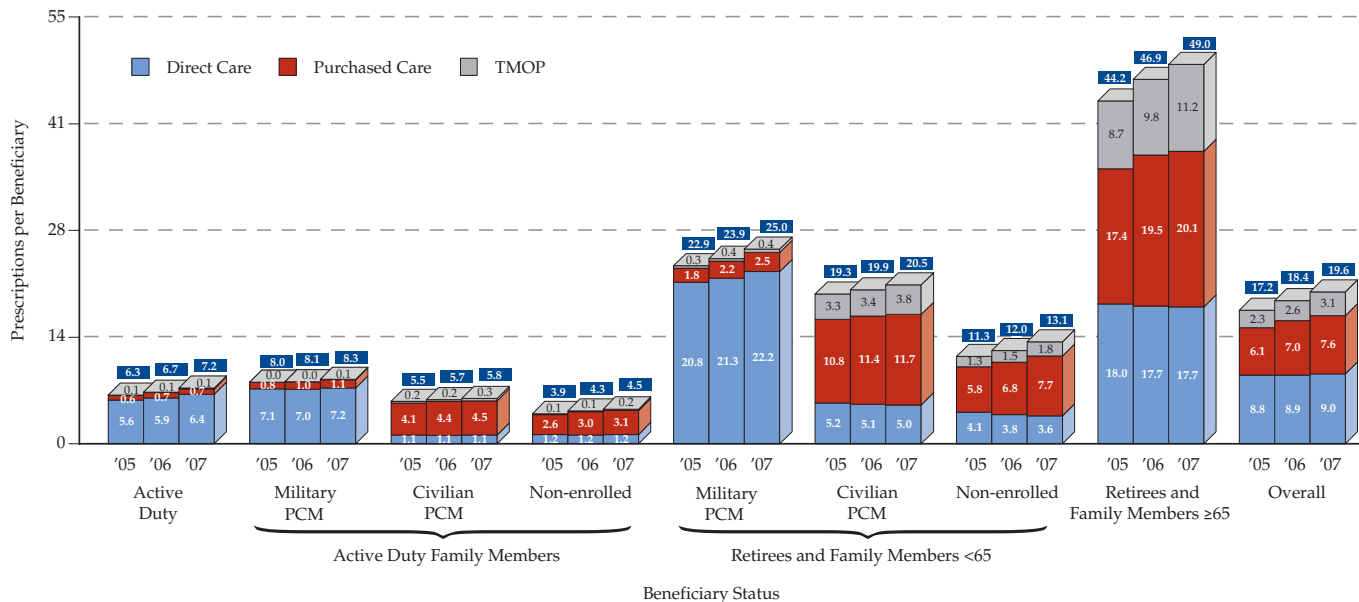
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS (CONT'D)

TRICARE Prescription Drug Utilization Rates by Beneficiary Status

Prescriptions include all initial and refill prescriptions filled at military pharmacies, retail pharmacies, and the TMOP. Prescription counts from these sources were normalized by dividing the total days supply for each by 30 days.

- The total (direct, retail, and TMOP) number of prescriptions per beneficiary increased by 13 percent from FY 2005 to FY 2007, exclusive of the TSRx benefit. Including TSRx, the total number of prescriptions increased by 14 percent.
- Average direct care prescription utilization increased by 2 percent. The direct care prescription utilization rate increased for all MTF-enrolled beneficiaries (particularly Active Duty) but fell substantially (12 percent) for non-enrolled retirees and family members.
- Average prescription utilization through nonmilitary pharmacies (civilian retail and mail order) increased sharply for all beneficiary groups but most notably for nonenrolled beneficiaries (32 percent).
- TMOP remains a relatively infrequent source of purchased care prescription utilization but its use has been increasing. When normalized by 30 days supply, TMOP utilization as a percentage of total purchased care prescription drug utilization increased from 27 percent in FY 2005 and FY 2006 to 29 percent in FY 2007.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY (BY FISCAL YEAR)



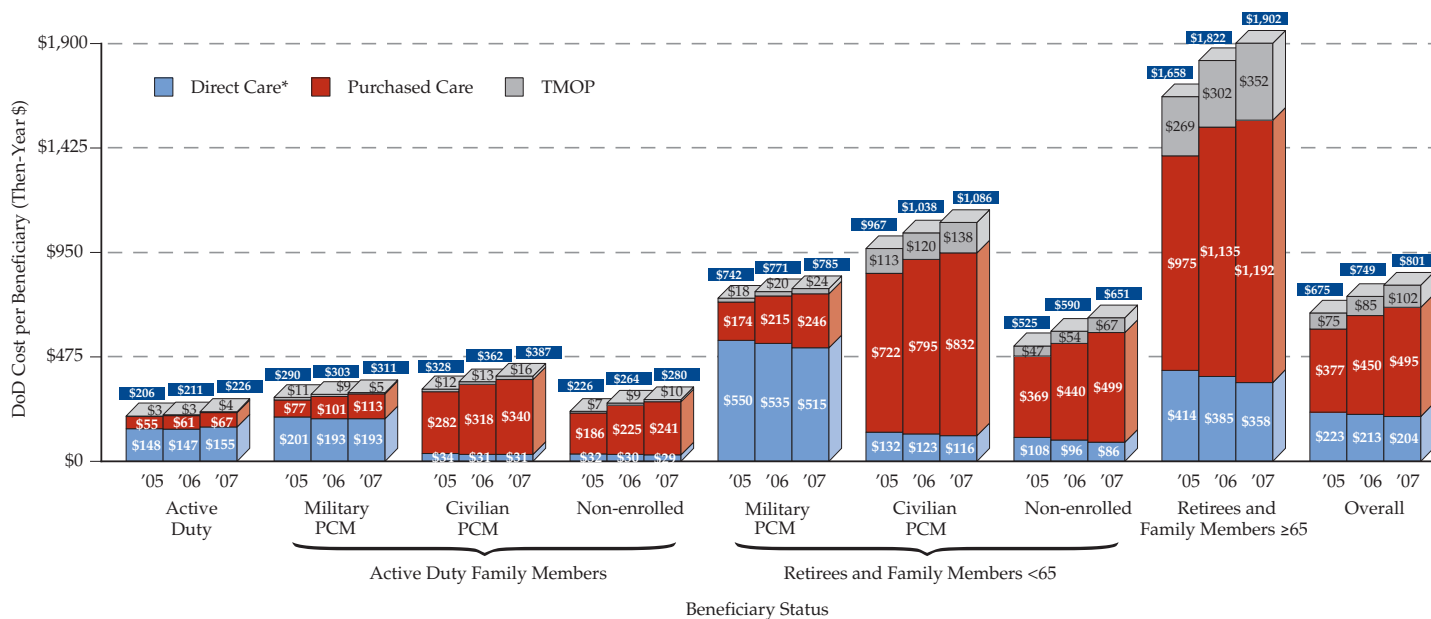
Source: MHS administrative data, 1/5/2008

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS (CONT'D)

Prescription Drug Cost by Beneficiary Status

- Prescription drug costs continued to rise at the fastest rate of any medical service, increasing by 19 percent irrespective of whether the TSRx benefit is included. About 75 percent of the cost increase was due to increased utilization.
- Direct care costs per beneficiary fell by 9 percent but retail pharmacy costs rose by 36 percent exclusive of TSRx and by 31 percent including TSRx.
- TMOP costs increased at about the same rate as retail pharmacy, increasing by 37 percent with or without TSRx.

AVERAGE ANNUAL PRESCRIPTION COSTS PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 1/5/2008

* Direct care prescription costs include an MHS-derived dispensing fee.

BENEFICIARY FAMILY OUT-OF-POCKET COSTS & OHI COVERAGE

Out-of-pocket costs are computed for Active Duty and retiree families grouped by sponsor age: (1) Under 65, and (2) 65 and older (seniors). Costs include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. For beneficiaries less than 65, costs are compared with those of civilian counterparts (i.e., civilian families with the same demographics as the typical MHS family). Civilian counterparts are assumed to be covered by employer-sponsored health insurance. Added drug benefits in April 2001 and the TFL Program in FY 2002 dramatically reduced costs for MHS seniors. For MHS seniors, costs are compared before and after these benefit changes.

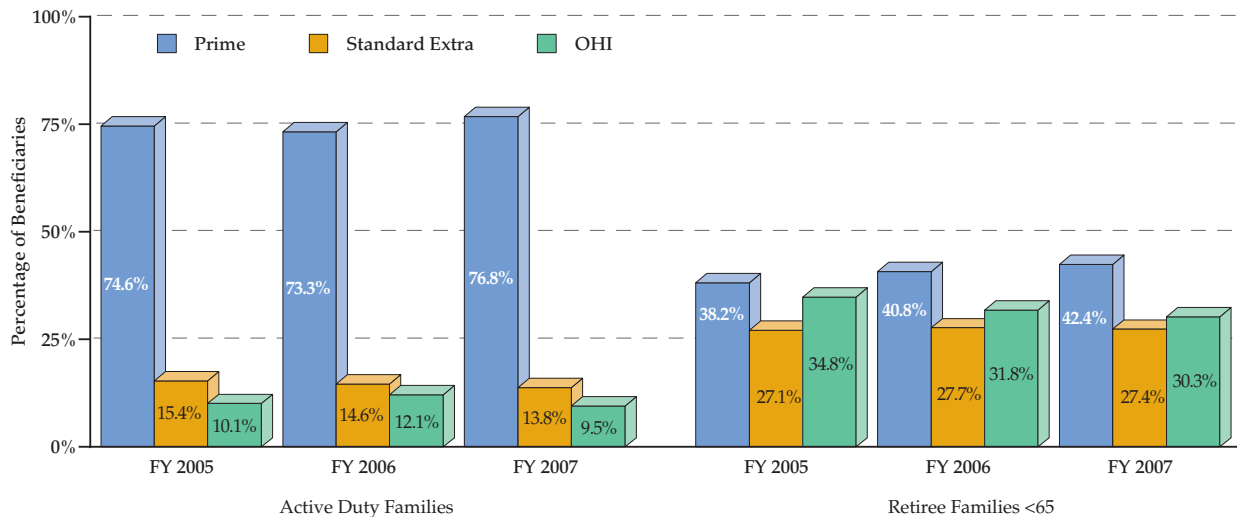
Health Insurance Coverage of MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of: (1) TRICARE Prime, (2) TRICARE Standard/Extra, and (3) other private health insurance (OHI). Most beneficiaries with OHI opt out of TRICARE entirely; some use TRICARE as a second payer.

Beneficiaries are grouped by their primary health plan:

- TRICARE Prime: Family enrolled in TRICARE Prime and no OHI. In FY 2007, 76.8 percent of Active Duty families and 42.4 percent of retiree families were in this group.
- TRICARE Standard/Extra: Family not enrolled in TRICARE Prime and no OHI. In FY 2007, 13.8 percent of ADFMs and 27.4 percent of retiree families were in this group.
- OHI: Family covered by OHI. In FY 2007, 9.5 percent of Active Duty families and 30.3 percent of retiree families were in this group.

HEALTH INSURANCE PLAN USERS



Source: FYs 2005–2007 administrations of the Health Care Surveys of DoD Beneficiaries (HCSDB)

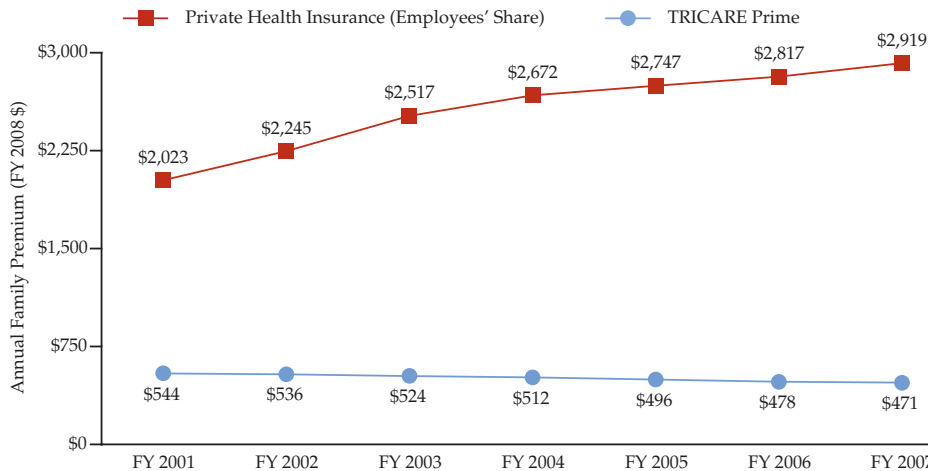
Note: The Prime group includes HCSDB respondents without OHI who are enrolled in Prime based on DEERS. The Standard/Extra beneficiary group includes HCSDB respondents without OHI who are non-enrollees based on DEERS. A small percentage of Prime enrollees are also covered by OHI. These beneficiaries are included in the OHI group.

BENEFICIARY FAMILY OUT-OF-POCKET COSTS & OHI COVERAGE (CONT'D)

Retirees and Family Members Under Age 65 Returning to the MHS

Since FY 2001, private health insurance premiums have been rising while the TRICARE enrollment fee has remained fixed at \$460 per retiree family. In constant FY 2008 dollars, the private health insurance premium increased by \$896 (44 percent) from FY 2001 to FY 2007, whereas the TRICARE premium declined by \$73 (–13 percent) during this period.

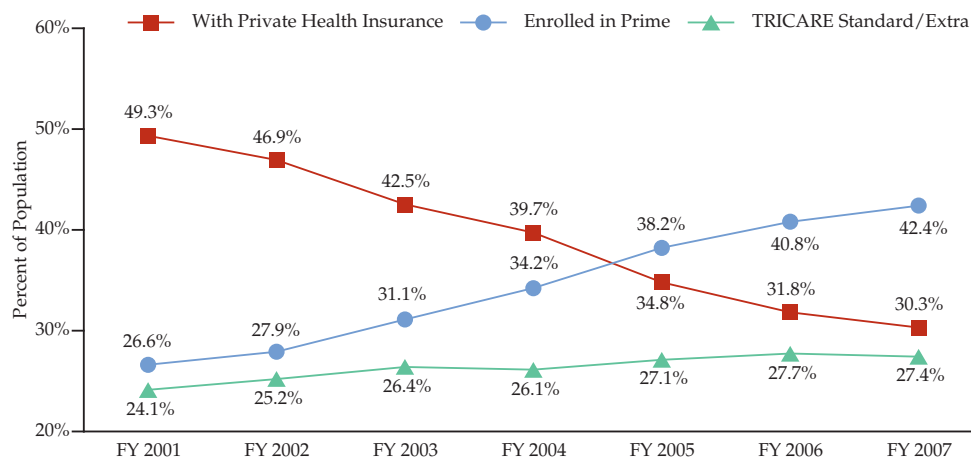
TREND IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT FEE



Sources: Employees' share of insurance premium for typical employer sponsored group health plan: Medical Expenditure Panel Surveys, 2000–2005; forecasted by Institute for Defense Analyses in FYs 2006–2007 using regression analysis. Consumer Price Index: Bureau of Labor Statistics.

The increasing disparity in premiums induced retirees to drop their private health insurance and enroll in Prime. The trend in insurance coverage translates into an additional 450,000 retirees and family members under age 65 who are using TRICARE Prime instead of private health insurance in FY 2007.

TREND IN RETIREE (<65) HEALTH INSURANCE COVERAGE



Sources: DEERS and Retirees Under Age 65 Health Care Beneficiary Surveys of DoD Beneficiaries, 2001–2007.

Note: The Prime enrollment rates above exclude those with OHI (about 4 percent of retirees).

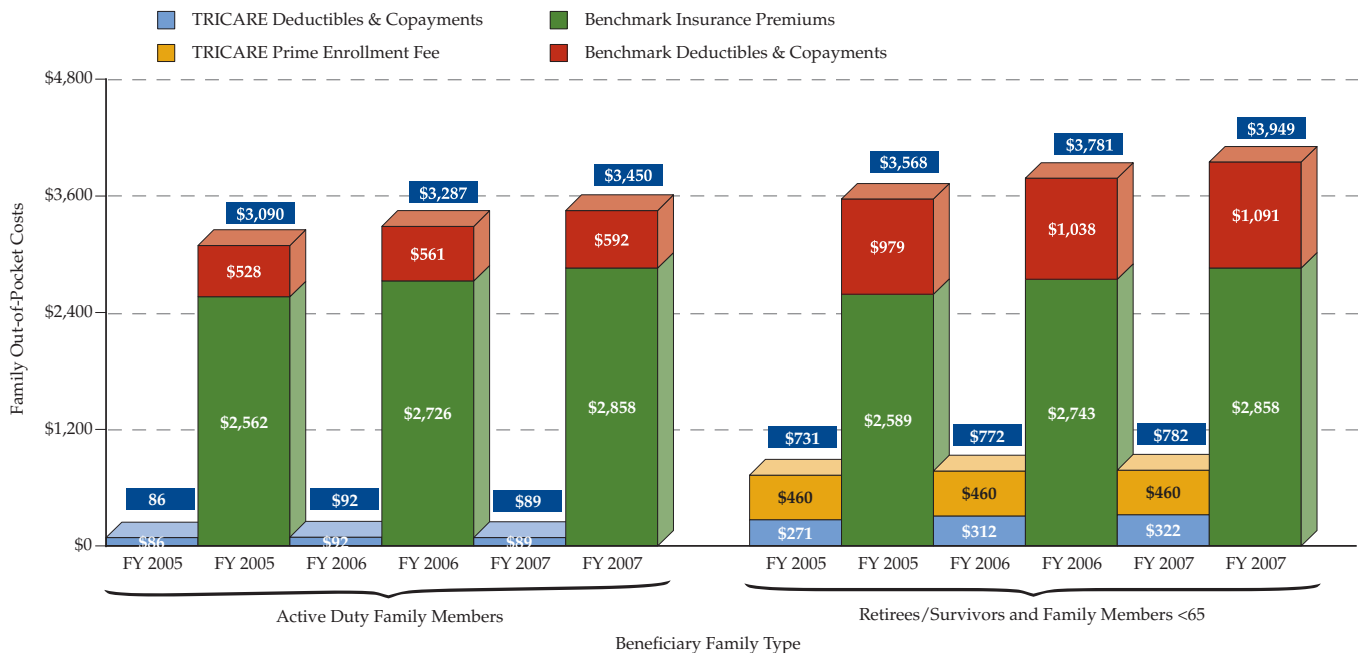
BENEFICIARY FAMILY OUT-OF-POCKET COSTS & OHI COVERAGE (CONT'D)

Out-of-Pocket Costs for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

In FYs 2005–2007, civilian counterpart families had substantially higher out-of-pocket costs than TRICARE Prime enrollees.

- Civilian HMO counterparts paid more for insurance premiums, deductibles, and copayments.
 - \$3,200 more than those incurred by retiree families enrolled in Prime.
- In FY 2007, costs for civilian counterparts were:
 - \$3,400 more than those incurred by Active Duty families enrolled in Prime.

OUT-OF-POCKET COSTS FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS (BY FISCAL YEAR)



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, 2005–07; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Survey projections, 2005–07; civilian insurance premiums from Medical Expenditure Panel Surveys; OHI coverage from Health Care Surveys of DoD Beneficiaries (HCSDB), 2005–07.

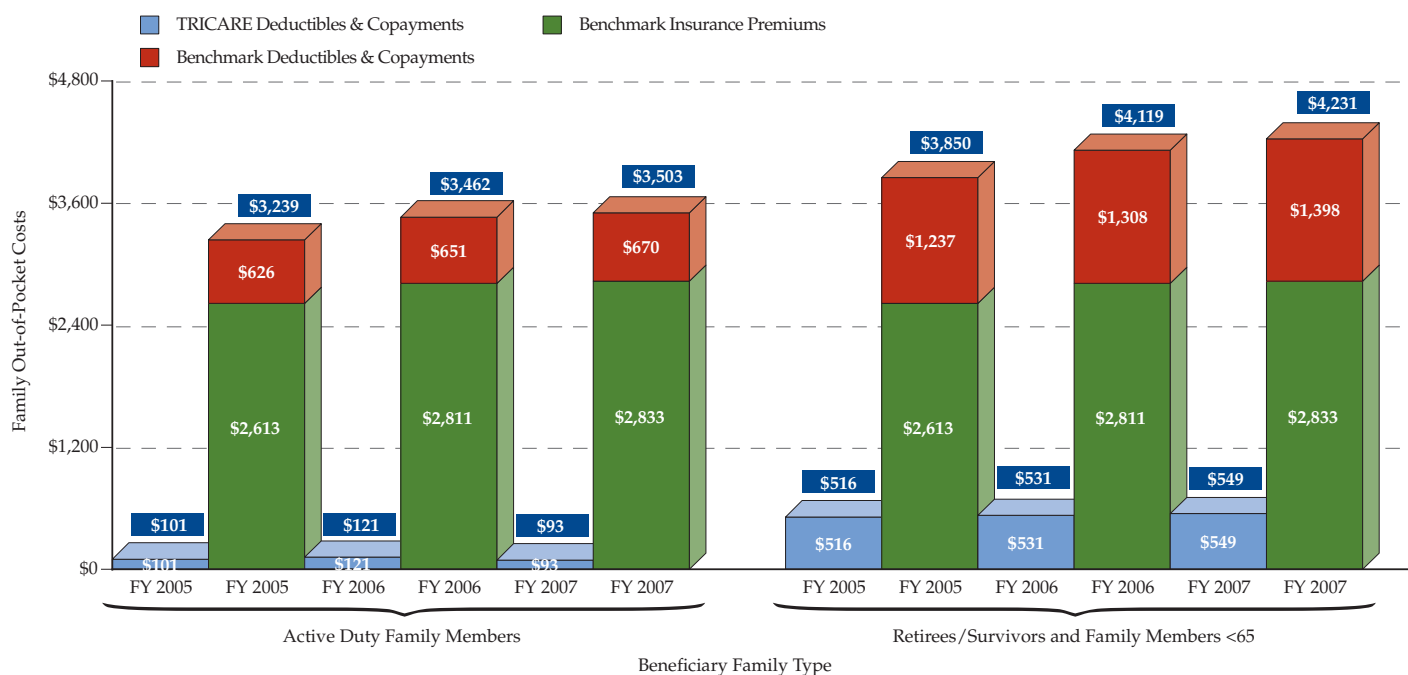
BENEFICIARY FAMILY OUT-OF-POCKET COSTS & OHI COVERAGE *CONT'D)*

Out-of-Pocket Costs for Families Not Enrolled in TRICARE Prime vs. Civilian PPO Counterparts

In FY 2005 to FY 2007, civilian counterparts had much higher out-of-pocket costs than TRICARE Standard/Extra users.

- Civilian PPO counterparts paid more for insurance premiums, deductibles, and copayments.
- In FY 2007, costs for civilian counterparts were:
 - \$3,400 more than those incurred by Active Duty families who relied on Standard/Extra.
 - \$3,700 more than retiree families who relied on Standard/Extra.

OUT-OF-POCKET COSTS FOR FAMILIES WHO RELY ON TRICARE STANDARD/EXTRA VS. CIVILIAN PPO COUNTERPARTS (BY FISCAL YEAR)



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, 2005–07; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Survey projections, 2005–07; civilian insurance premiums from Medical Expenditure Panel Surveys; OHI coverage from Health Care Surveys of DoD Beneficiaries (HCSDB), 2005–07.

BENEFICIARY FAMILY OUT-OF-POCKET COSTS & OHI COVERAGE (CONT'D)

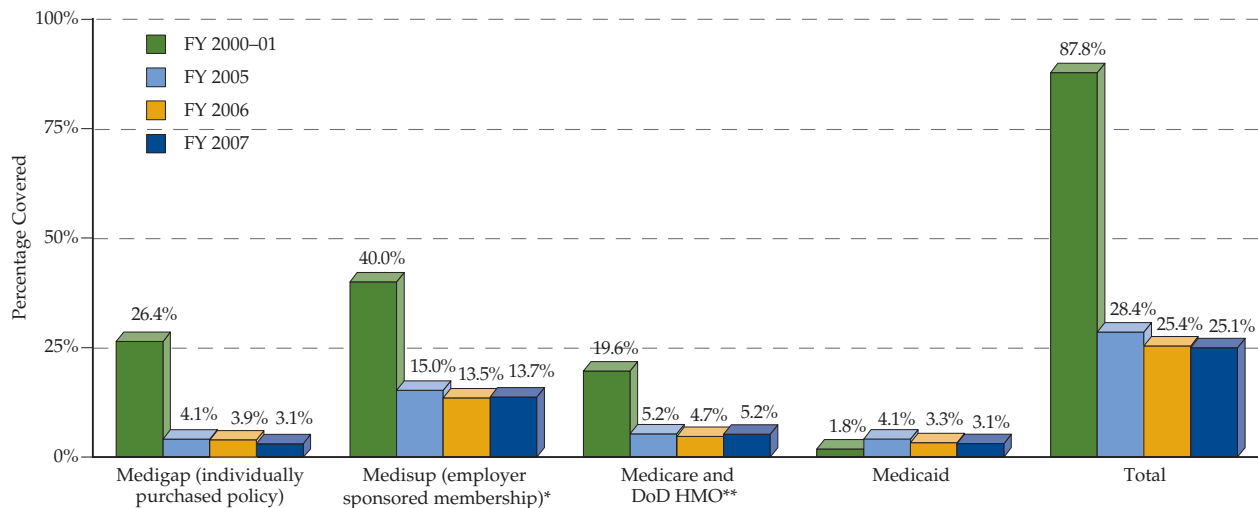
Health Insurance Coverage of MHS Senior Beneficiaries

Medicare provides coverage for medical services and requires substantial deductibles and copayments; it did not begin to cover prescription drugs until 2006. Until FY 2001, most MHS seniors purchased some type of Medicare Supplemental insurance. A small number were active employees with employer-sponsored insurance (OHI) or were covered by Medicaid. Out-of-pocket costs include deductibles/copayments and premiums for Medicare Part B, supplementary insurance, and OHI.

In April 2001, DoD expanded drug benefits for seniors and on October 1, 2001, implemented the TFL program, which provides free Medicare supplemental insurance. Because of these programs, most MHS seniors dropped their supplemental insurance. According to the Health Care Surveys of DoD Beneficiaries in 2000–2001 and 2005–2007:

- Before TFL (FY 2000–01), 87.8 percent of MHS seniors had some type of Medicare supplemental insurance or were covered by Medicaid. After TFL, the percentage of MHS seniors with supplemental insurance or Medicaid fell sharply, to 28.4 percent in FY 2005. It declined to 25.1 percent in FY 2007.
- Why do a quarter of all seniors still retain some form of other health insurance when they can use TFL for free? Some possible reasons are:
 - A lack of awareness of the TFL benefit.
 - Higher family costs if a spouse is not yet Medicare eligible. Dropping a non-Medicare-eligible spouse from an employer-sponsored plan (spouse-only plans are generally not available) can result in higher family costs if the spouse must purchase a nonsubsidized individual policy.

MEDICARE SUPPLEMENTAL INSURANCE COVERAGE OF MHS SENIORS (PERCENT)



Source: FYs 2000–2001 and FYs 2005–2007 administrations of the Health Care Surveys of DoD Beneficiaries

* From current or former federal, state, or civilian employers.

** DoD HMOs include TRICARE Senior Prime and the Uniformed Services Family Health Plan.

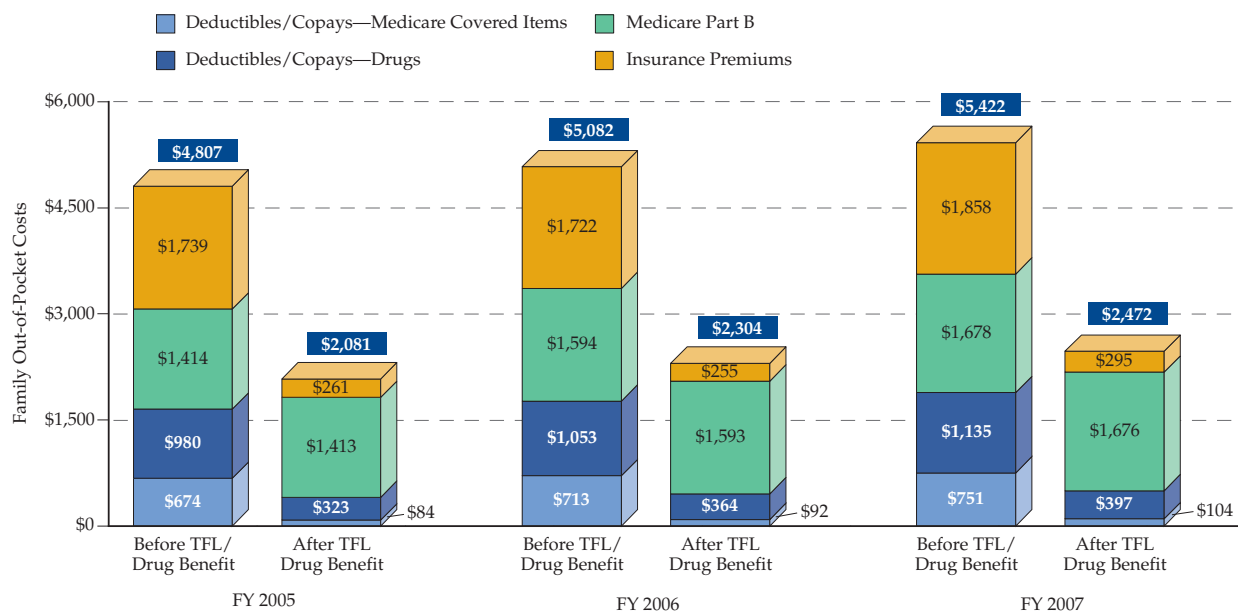
BENEFICIARY FAMILY OUT-OF-POCKET COSTS & OHI COVERAGE (CONT'D)

Out-of-Pockets Costs for MHS Senior Families Before and After TFL

TFL and added drug benefits have enabled MHS seniors to reduce their expenses for supplemental insurance, deductibles, and copayments.

- MHS senior families saw their out-of-pocket expenses reduced by about 55 percent in FYs 2005–2007.
- In FY 2007, MHS senior families saved \$2,900 as a result of TFL.

OUT-OF-POCKET COSTS OF MHS SENIOR FAMILIES VS. CIVILIAN COUNTERPARTS (BY FISCAL YEAR)



Sources: DoD beneficiary expenditures from MHS administrative data; civilian expenditures from Medical Expenditure Panel Survey projections, 2005–07; Medicare and Medicare HMO premiums from Centers for Medicare and Medicaid Services; Medigap premiums from TheStreet.com Ratings; Medisup premiums from Tower Perrin Health Care Cost Survey 2005–2007; OHI and Medicare supplemental insurance coverage from Health Care Surveys of DoD Beneficiaries, 2005–07.

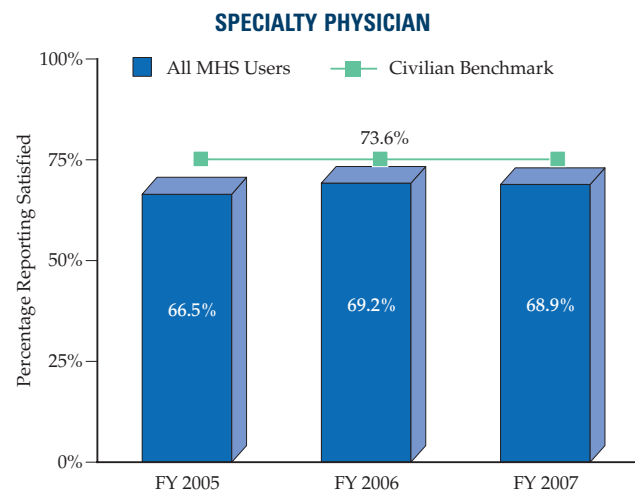
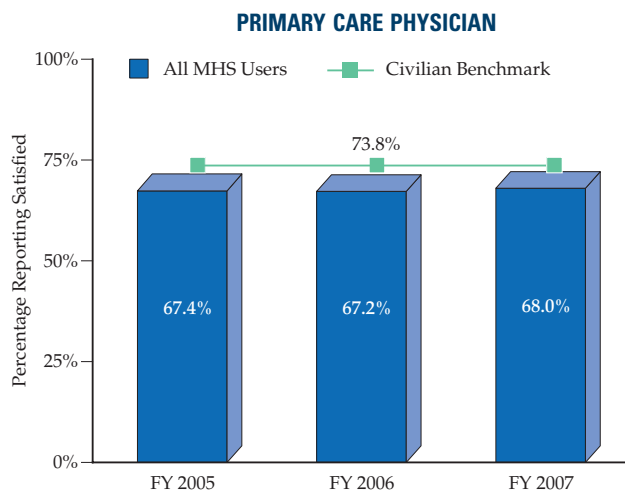
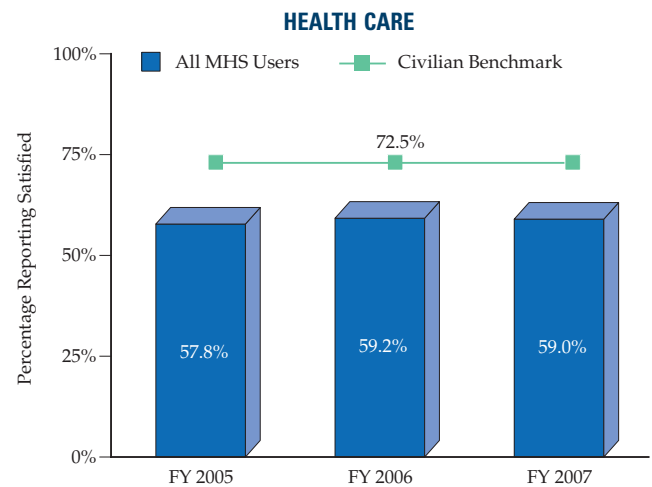
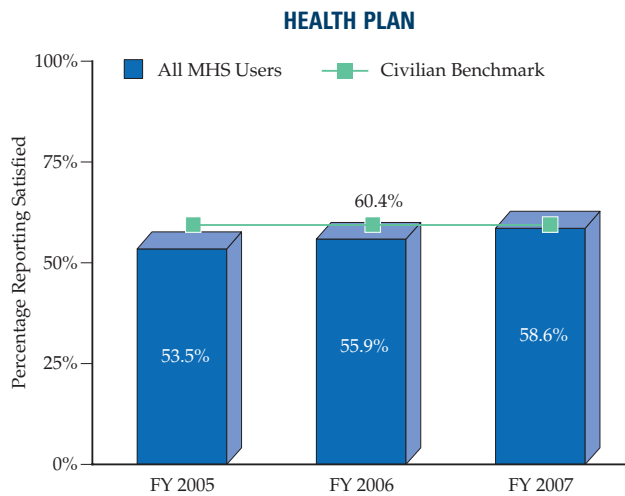
This section focuses on scanning the health care environment for relevant benchmarks, applying their metrics, and striving to meet or exceed those standards. The metrics presented here focus on customer satisfaction and health promotion activities through Building Healthy Communities.

CUSTOMER SATISFACTION WITH KEY ASPECTS OF TRICARE

The health care consumer satisfaction surveys used by the MHS and many commercial plans ask beneficiaries to rate various aspects of their health care. MHS beneficiaries in the United States who have used TRICARE are compared with the civilian benchmark with respect to ratings of (1) the health plan, in general; (2) health care; (3) personal physician; and (4) specialty care. The civilian benchmark is based on health care system performance metrics from the national Consumer Assessment of Health Care Providers and Systems (CAHPS). Health plan ratings depend on access to care and how the plan handles various service aspects such as claims, referrals, and customer complaints.

- Satisfaction with the overall TRICARE plan, health care, and one's specialty physician improved between FY 2005 and FY 2007. Satisfaction with one's personal physician remained stable during this three-year period.
- MHS satisfaction rates continue to lag civilian benchmarks.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS



Note: DoD data were derived from the FYs 2005–2007 Health Care Survey of DoD Beneficiaries (HCSDB) as of 11/27/07 and adjusted for age and health status. Ratings are on a 0–10 scale, with “Satisfied” defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

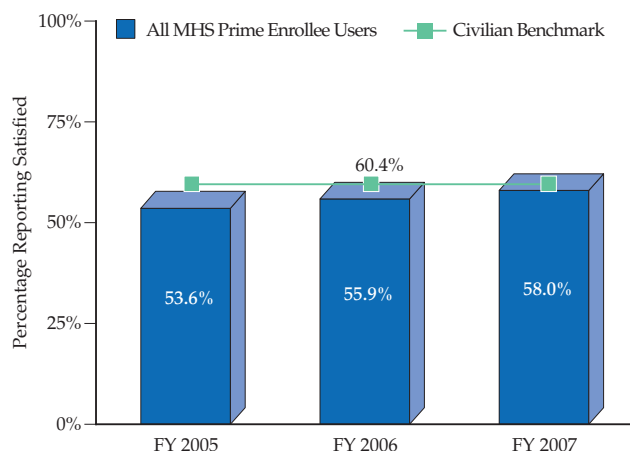
SATISFACTION WITH THE HEALTH PLAN BASED ON ENROLLMENT STATUS

DoD health care beneficiaries can participate in TRICARE in several ways: By enrolling in the Prime option or by not enrolling and using the traditional indemnity option for seeing participating providers (Standard) or network providers (Extra). Satisfaction levels with one's health plan across the TRICARE options are compared with commercial plan counterparts.

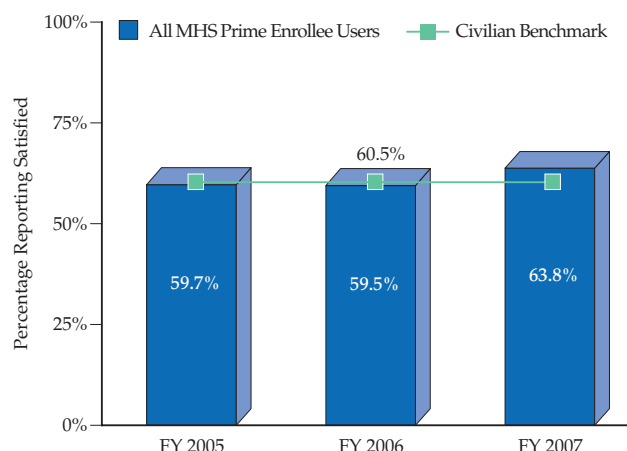
- Satisfaction increased from FY 2005 to FY 2007 for Prime enrollees (with a military PCM as well as with civilian PCMs) and non-enrollees alike.
- During each of the past three years (FY 2005 to FY 2007), MHS beneficiaries enrolled with civilian network providers reported the same (FY 2005 to FY 2006) or higher (FY 2007) level of satisfaction than their civilian counterparts (i.e., for FY 2005 and FY 2006 there were no statistically significant differences in the proportions; and, for FY 2007, MHS enrollees were statistically significantly higher).
- MHS beneficiaries enrolled with military PCMs reported lower levels of satisfaction than their civilian plan counterparts; while satisfaction levels of non-enrollees increased from below the civilian benchmark to comparability by FY 2007.

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BASED ON ENROLLMENT STATUS

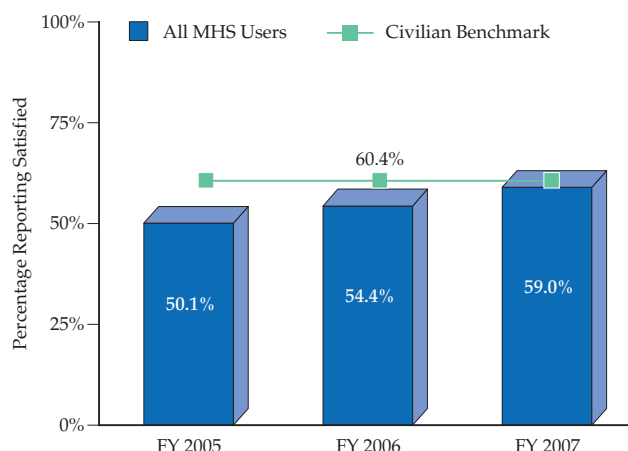
PRIME: MILITARY PCM



PRIME: CIVILIAN PCM



STANDARD/EXTRA (NOT ENROLLED)



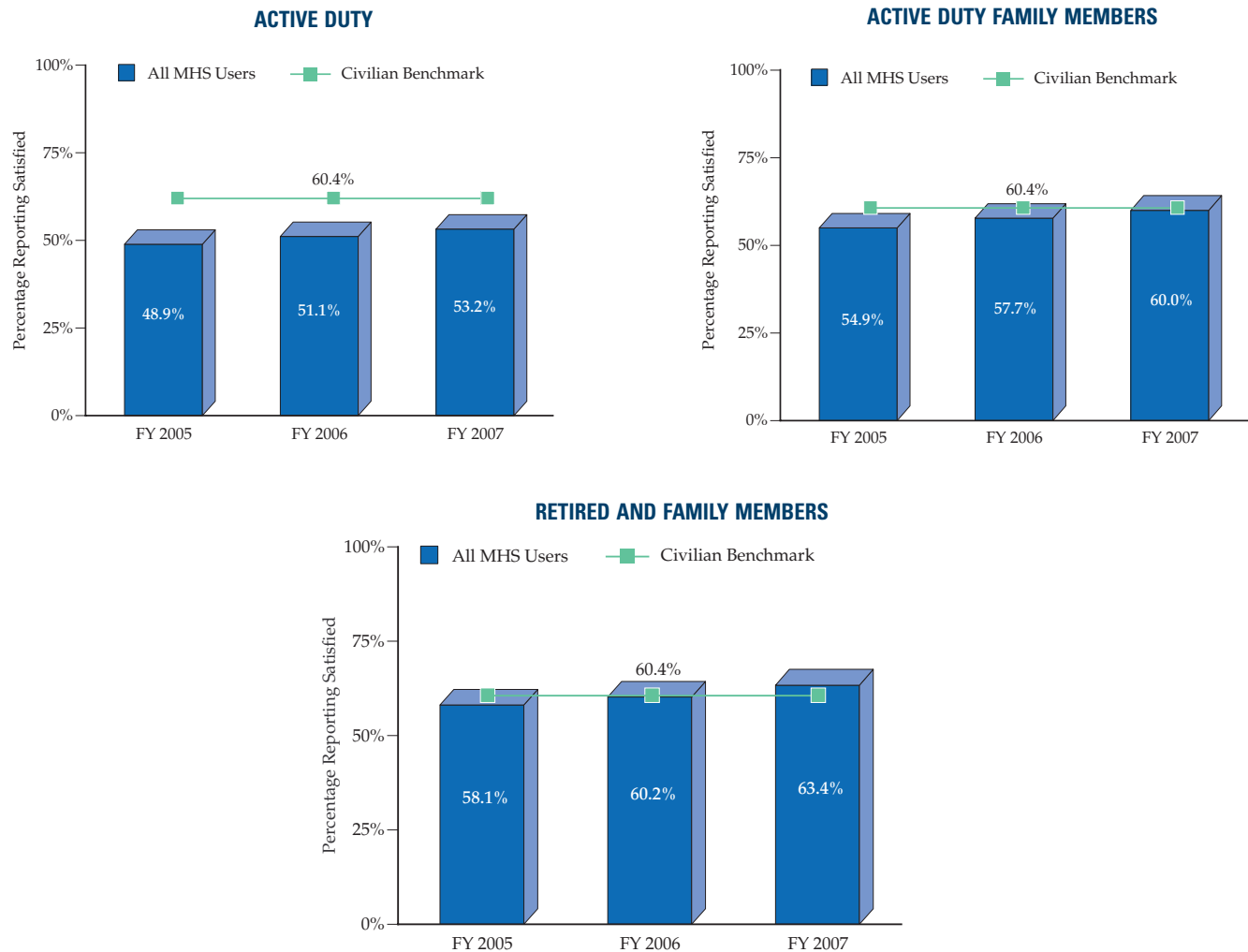
Note: DoD data were derived from the FYs 2005–2007 Health Care Survey of DoD Beneficiaries (HCSDB) as of 11/27/2007 and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY

Satisfaction levels of different beneficiary categories are examined to identify any diverging trends among groups.

- Satisfaction with the TRICARE health plan improved for all beneficiary categories between FY 2005 and FY 2007. Satisfaction of retired DoD beneficiaries was lower than their civilian counterparts in FY 2005, was comparable in FY 2006, and exceeded their rates in FY 2007.
- While both Active Duty and their family member ratings have lagged the civilian benchmarks, by FY 2007 family member satisfaction had increased to a level statistically comparable to the civilians.

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY



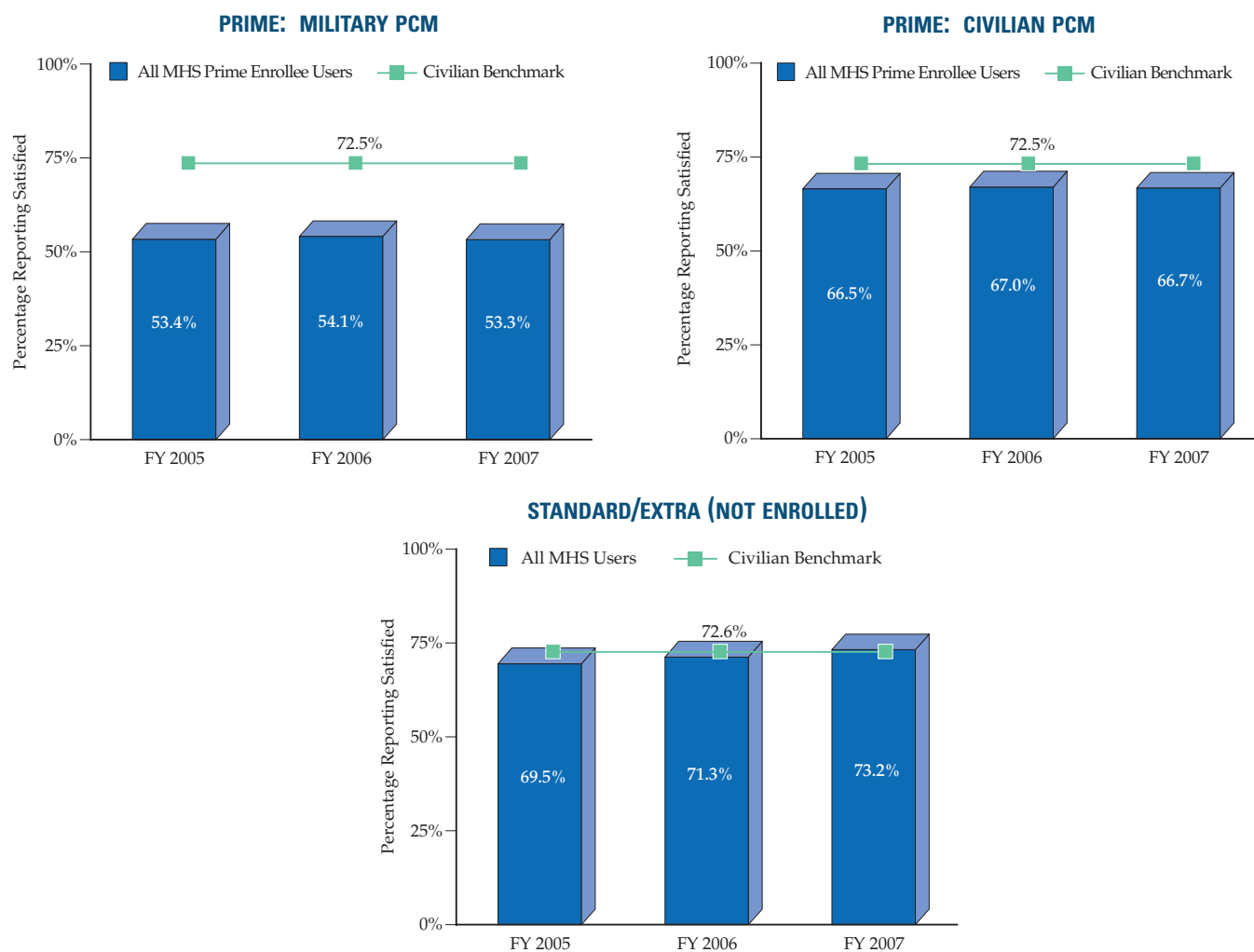
Note: DoD data were derived from the FYs 2005–2007 Health Care Survey of DoD Beneficiaries (HCSDb) as of 11/27/2007 and adjusted for age and health status. Ratings are on a 0–10 scale, with “Satisfied” defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDb methodology.

SATISFACTION WITH THE HEALTH CARE BASED ON ENROLLMENT STATUS

Similar to satisfaction with the TRICARE health Plan, satisfaction levels with the health care received differ by enrollment status:

- Between FY 2005 and FY 2007, non-enrollee satisfaction increased, and for the past two years was comparable to the civilian benchmark (bottom chart, for FY 2006 and FY 2007).
- Between FY 2005 and FY 2007, MHS Prime enrollee satisfaction with their health care remained unchanged, and continued to lag the civilian benchmark.

TRENDS IN SATISFACTION WITH THE HEALTH CARE BASED ON ENROLLMENT STATUS



Note: DoD data were derived from the FYs 2005–2007 Health Care Survey of DoD Beneficiaries (HCSDB) as of 11/27/2007 and adjusted for age and health status. Ratings are on a 0–10 scale, with “Satisfied” defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

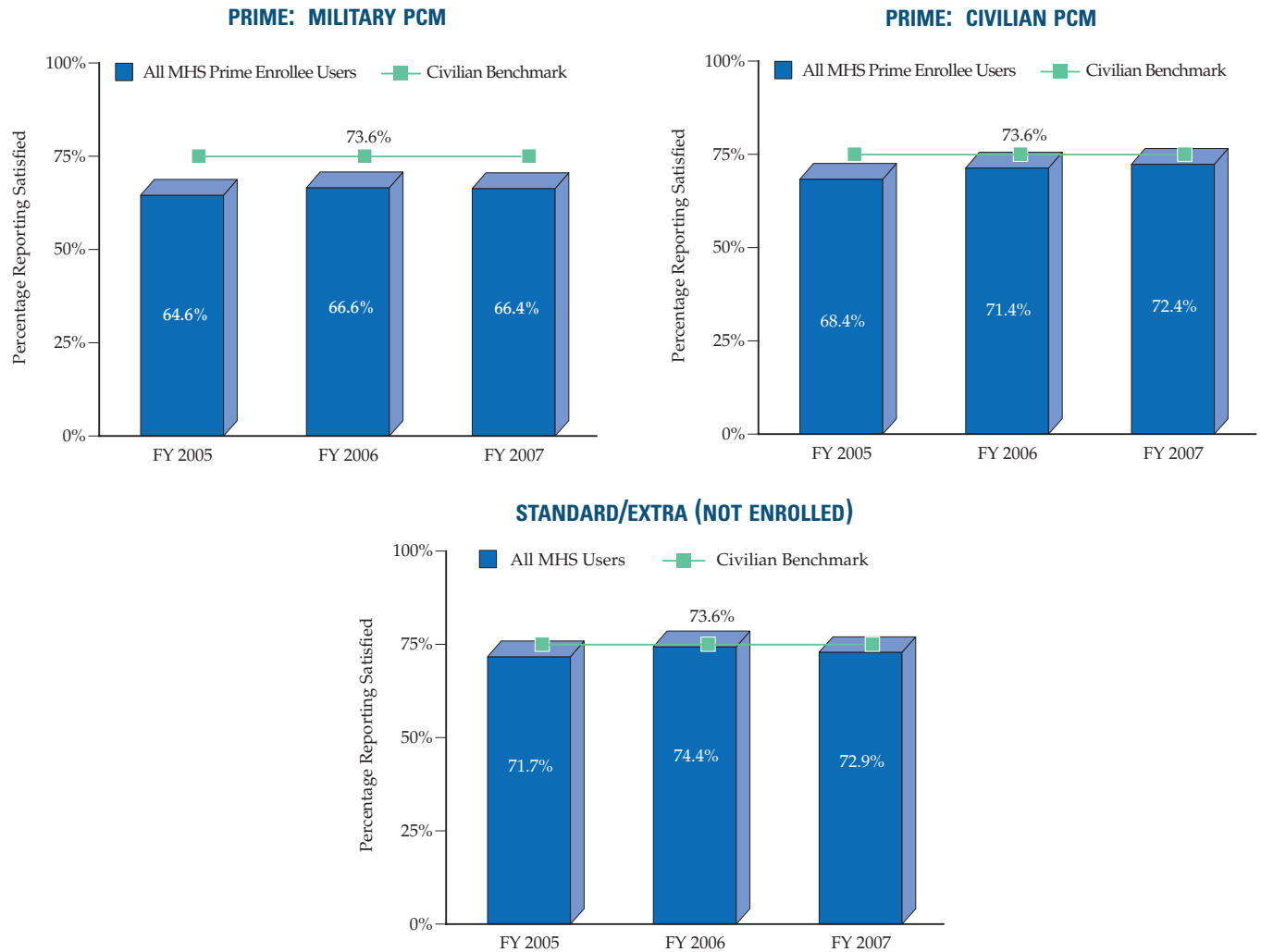
SATISFACTION WITH ONE'S SPECIALTY PROVIDER BASED ON ENROLLMENT STATUS

MHS user satisfaction with their specialty providers has remained unchanged over the past three years, from FY 2005 to FY 2007, irrespective of enrollment status.

- Prime enrollees with civilian PCMs have reported satisfaction levels comparable to the civilian benchmark for the past two years (FY 2006 and

FY 2007), while non-enrollee user satisfaction has been comparable for the past three years (i.e., no statistically significant differences).

TRENDS IN SATISFACTION WITH ONE'S SPECIALTY PROVIDER BASED ON ENROLLMENT STATUS



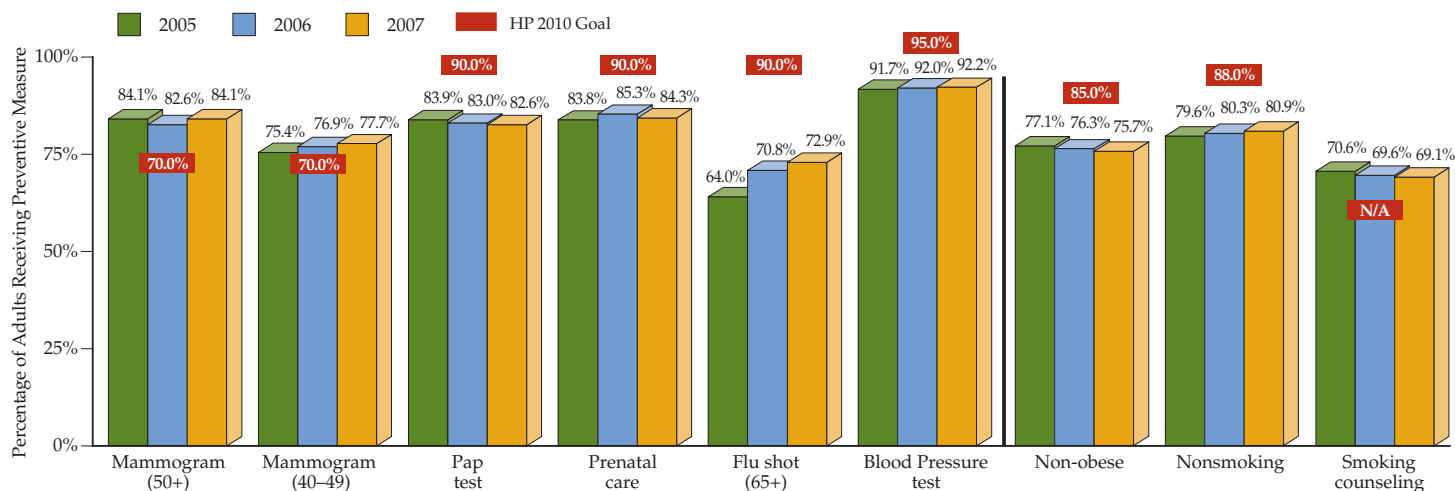
Note: DoD data were derived from the FYs 2005–2007 Health Care Survey of DoD Beneficiaries (HCSDB) as of 11/27/2007 and adjusted for age and health status. Ratings are on a 0–10 scale, with “Satisfied” defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

BUILDING HEALTHY COMMUNITIES – HP 2010

Healthy People (HP) goals represent the prevention agenda for the Nation over the past two decades (www.healthypeople.gov/About/). Beginning with goals established for Healthy People 2000 (HP 2000) and maturing most recently in Healthy People 2010 (HP 2010), this agenda is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats. These strategic goals go beyond restorative care and speak to the challenges of institutionalizing population health within the MHS. There are many indices by which to monitor the MHS relative to HP goals and reported civilian progress. The MHS has improved in several key areas and strives to improve in others.

- The MHS has set as goals a subset of the health-promotion and disease-prevention objectives specified by HHS in HP 2010. These goals and objectives go beyond restorative care and speak to the need to institutionalize population health within the MHS. Over the past three years, the MHS has met or exceeded targeted HP 2010 goals in providing mammograms (for ages 40–49 years as well as 50+ categories).
- Efforts continue toward achieving HP 2010 standards for Pap smears, prenatal exams and flu shots (for people age 65 and older), and blood pressure screenings.
- **Tobacco Use:** The overall self-reported nonsmoking rate among all MHS beneficiaries remained the same from FY 2005 through FY 2007. While the proportion of non-smoking MHS beneficiaries appears higher than the overall U.S. population (not shown), it continues to lag the HP 2010 goal of an 88 percent nonsmoking rate (age and sex standardized against the HP goal of 12 percent rate in tobacco use for individuals smoking at least 100 cigarettes in a lifetime, and smoking in the last month).
- **Obesity:** The metric of “non-obese” has been established to indicate a general sense of the population likely not excessively overweight and at health risk due to obesity. The overall proportion of all MHS beneficiaries identified as non-obese has remained relatively constant from FY 2005 to FY 2007. The MHS rate of 76 percent non-obese in FY 2007 using self-reported data, has not reached the HP 2010 goal of 85 percent, but does exceed the most recently identified U.S. population average of 69 percent (not shown).
- Still other areas continue to be monitored in the absence of specified HP standards, such as smoking-cessation counseling, which appears to be heading in the right direction, reaching almost 70 percent in FY 2007.

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FY 2005 TO FY 2007



Source: Health Care Survey of DoD Beneficiaries and the National CAHPS Benchmarking Database as of 11/30/2007

MHS-TARGETED PREVENTIVE CARE OBJECTIVES

Mammogram: Women age 50 or older who had mammogram in past year; women age 40–49 who had mammogram in past two years.

Pap test: All women who had a Pap test in last three years.

Prenatal: Women pregnant in last year who received care in first trimester.

Flu shot: People 65 and older who had a flu shot in last 12 months.

Blood Pressure test: People who had a blood pressure check in last two years and know results.

Non-Obese: Obesity is measured using the Body Mass Index (BMI), which is calculated from self-reported data from the Health Care Survey of DoD Beneficiaries. An individual's BMI is calculated using height and weight ($BMI = 703 \text{ times weight in pounds, divided by height in inches squared}$.) While BMI is a risk measure, it does not measure actual body fat; as such, it provides a preliminary indicator of possible excess weight, which in turn, provides a preliminary indicator of risk associated with excess weight. It should therefore be used in conjunction with other assessments of overall health and body fat.

Smoking cessation counseling: People advised to quit smoking in last 12 months.

DoD 2006 SURVEY OF HEALTH RELATED BEHAVIORS AMONG MILITARY PERSONNEL

Findings from the 2006 DoD Survey of Health Related Behaviors (HRB) among Guard and Reserve Personnel—A Component of the DoD Lifestyle Assessment Program (DLAP)

The most recent Survey of HRB for Active Duty was completed in FY 2005 and reported in FY 2006. The 2005 survey was the ninth in a series of surveys of Active Duty military personnel, with previous studies conducted in 1980, 1982, 1985, 1988, 1992, 1995, 1998, and 2002. All these surveys investigated the prevalence of alcohol use, illicit drug use, and tobacco use, as well as negative consequences associated with substance use. The survey has evolved over time, with revisions and additions to accommodate new areas of concern (e.g., mental health of the force). Key results were presented in last year's Evaluation of the TRICARE Program report for tobacco, alcohol, and substance use (Fiscal Year 2007 Report, p. 29).

The DLAP was initiated in 2005 to build on the health behavior surveys of Active Duty. The purpose of this program is to:

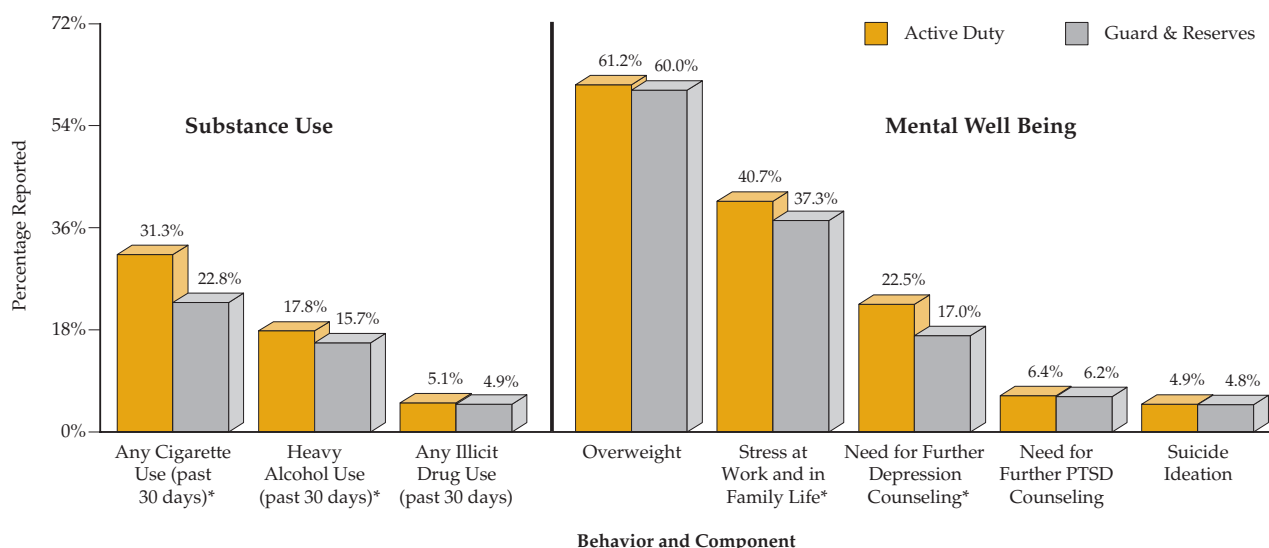
- Assess lifestyle factors affecting health and readiness.
- Identify/track health-related trends and high-risk groups.
- Target groups and/or lifestyle factors for intervention.
- Help identify future directions for additional studies, DoD programs, and policies.

In 2006, the HRB was extended to include an assessment of members of the Reserve Component. The 2006 HRB is the largest anonymous population-based health behavior survey of Reserve Component personnel, and the first survey of its kind conducted on this population. Reserve Component personnel were selected from randomly selected clusters and the hard-copy survey fielded to personnel anonymously through on-site administration (80 percent) with mail questionnaires sent to nonclustered, remote installations (20 percent). Results are based on:

- 18,342 usable questionnaires overall (including full-time and/or activated Guard/Reservists).
- An overall response rate of 55.3 percent (completed questionnaires/number expected to be drilling on data collection weekend).

As shown in the chart below, with the exception of "any cigarette use in the past 30 days," there are no statistically significant differences between Active Duty and Reserve Component personnel in substance use or mental well being. Active Duty personnel, however, are more likely to have smoked any cigarettes in 30 days prior to taking the survey than their reserve counterparts, after adjusting for sociodemographic differences.

2006 DoD SURVEY OF HEALTH RELATED BEHAVIORS AMONG GUARD AND RESERVE PERSONNEL (ADJUSTED FOR SOCIODEMOGRAPHIC DIFFERENCES)



* Statistically significant at $p \leq 0.05$

Source: HA/TMA survey results, 12/11/2007

ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS

Sustaining the benefit is anchored on a number of supporting factors, including access to, and promptness of, health care services, customer services, and the availability of appropriate health care providers. This section enumerates several areas routinely monitored by the MHS leadership addressing patient access and clinical quality processes and outcomes, including: (1) Self-reported access to MHS care overall, (2) satisfaction with various aspects of the MHS (e.g., the availability and ease of obtaining care, getting providers of choice, and access to civilian physicians willing to accept TRICARE Standard), (3) responsiveness of customer service, quality, and timely claims processing (both patient reported as well as tracking through administrative systems), (4) Joint Commission quality metrics in MTFs compared to Commission findings nationwide, and (5) access to and satisfaction with MTF care.

Access to MHS Care

Using survey data, four categories of access to care were considered:

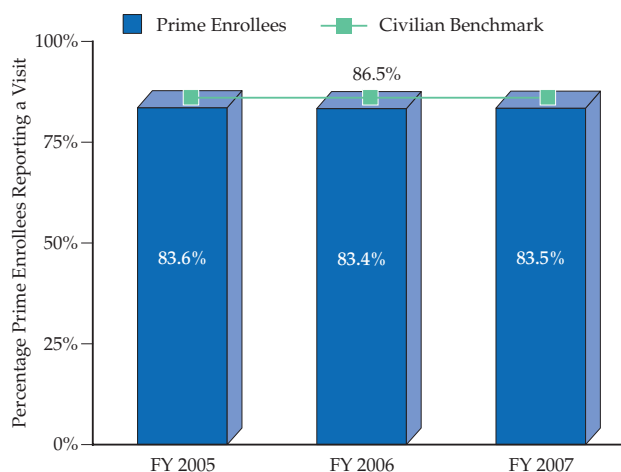
- Access based on reported use of the health care system in general.
- Availability and ease of obtaining care, and getting a provider of choice.
- Responsive customer service.
- Quality and timeliness of claims processing.

Overall Outpatient Access

The ability to see a doctor reflects one measure of successful access to the health care system, as depicted below when Prime enrollees were asked whether they had at least one outpatient visit during the past year.

- Access to, and use of, outpatient services remains high with 83 percent of all Prime enrollees (with military as well as civilian providers) reporting having at least one visit each year from FY 2005 to FY 2007.
- The MHS Prime enrollee rate continues to be three percentage points lower than the civilian benchmark each year (statistically significantly different each year).

TRENDS IN PRIME ENROLLEES HAVING AT LEAST ONE OUTPATIENT VISIT DURING THE YEAR



Note: DoD data were derived from the FYs 2005–2007 DoD Health Care Survey of DoD Beneficiaries (HCSDB) as of 11/27/2007, and adjusted for age and health status. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to Survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS (CONT'D)

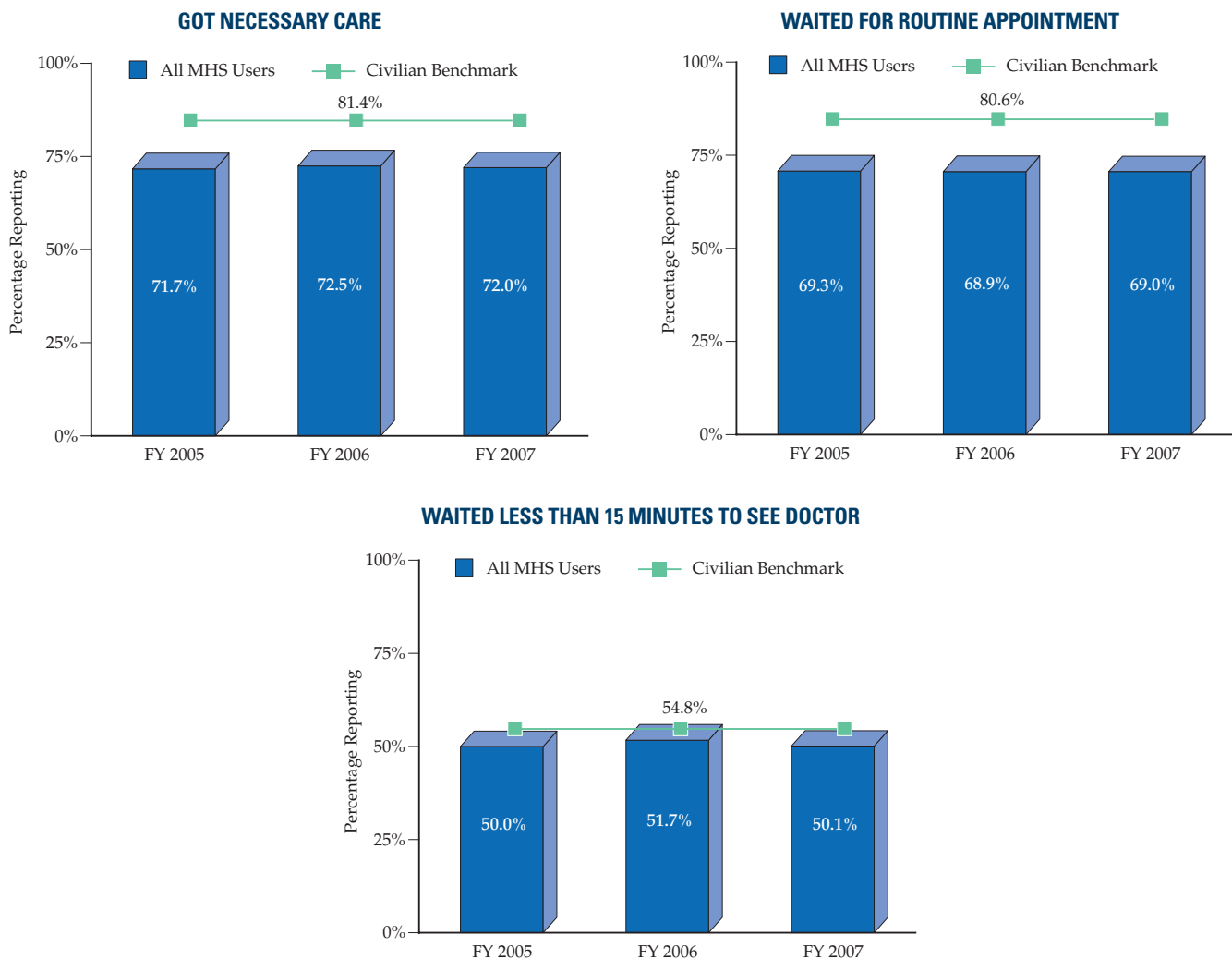
Availability and Ease of Obtaining Care

Availability and ease of obtaining care can be characterized by the extent to which beneficiaries report their ability to (1) receive care when needed, (2) obtain appointments in a timely fashion, and (3) avoid unnecessarily long waits in the doctor's office.

- MHS beneficiary ratings for three core measures of the availability and ease of accessing care remained stable between FY 2005 and FY 2007: Getting necessary care, waiting for a

routine appointment, and waiting less than 15 minutes in the doctor's office. All three measures lagged the civilian benchmark, which also remained stable during the same period.

TRENDS IN AVAILABILITY AND EASE OF OBTAINING CARE FOR ALL MHS BENEFICIARIES (ALL SOURCES OF CARE)



Note: DoD data were derived from the FYs 2005–2007 Health Care Survey of DoD Beneficiaries (HCSDB) as of 11/27/2007, and adjusted for age and health status. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

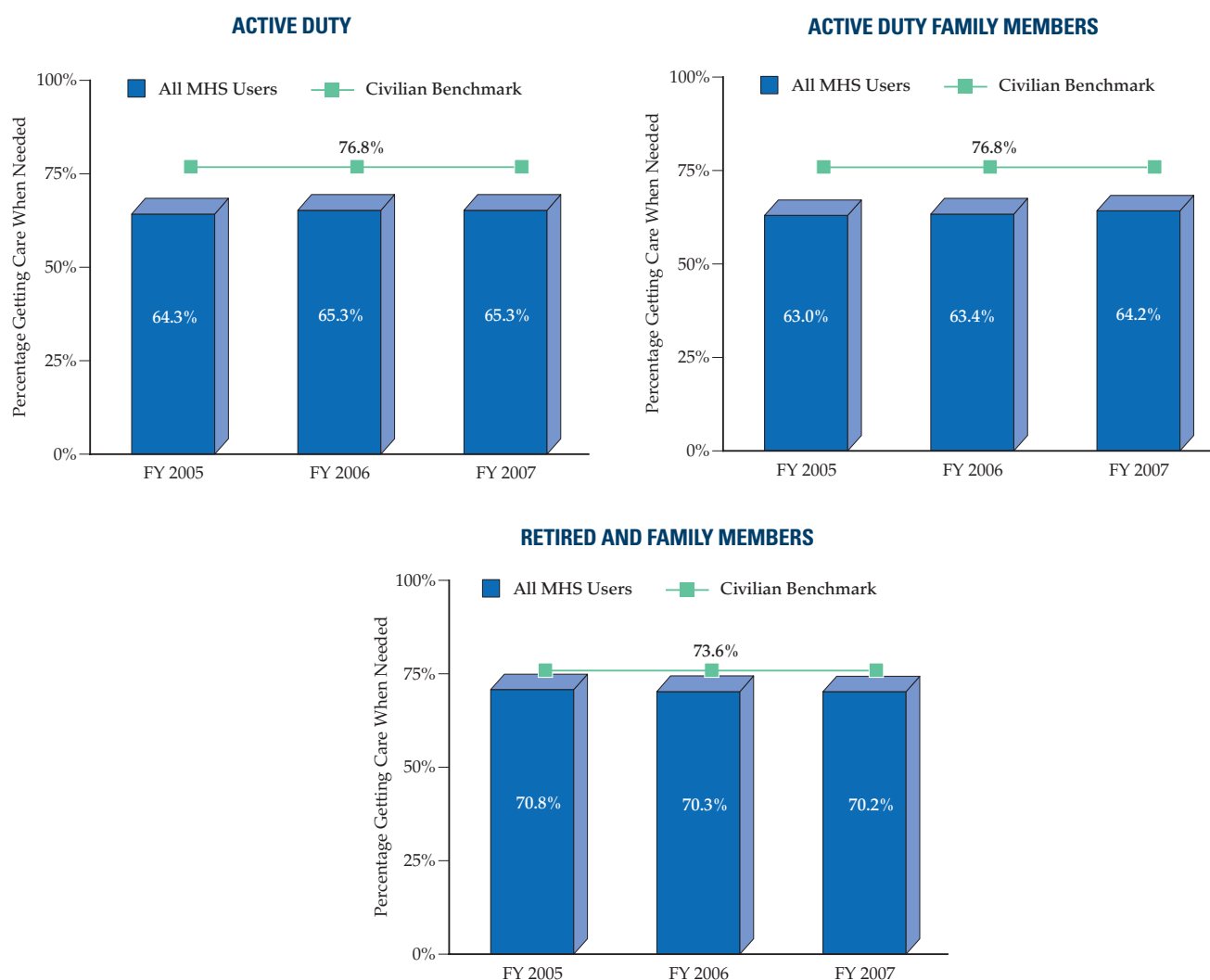
ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS (CONT'D)

Ability to Obtain Needed Care by Beneficiary Category

The following charts present beneficiary reported perceptions of their ability to obtain care, by examining differences in their beneficiary category.

- Retired beneficiaries continue to report higher levels of satisfaction with their ability to get care than Active Duty personnel or their family members.
- The MHS and civilian benchmarks remained stable across the three-year period from FY 2005 to FY 2007. Therefore, the disparity between the lower MHS satisfaction levels and the higher civilian benchmark remained stable as well.

TRENDS IN SATISFACTION WITH ABILITY TO OBTAIN CARE BY BENEFICIARY CATEGORY (ALL SOURCES OF CARE)



Note: DoD data were derived from the FYs 2005–2007 Health Care Survey of DoD Beneficiaries (HCSDb) as of 11/27/2007 and adjusted for age and health status. Ratings are on a 0–10 scale, with “Satisfied” defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDb methodology.

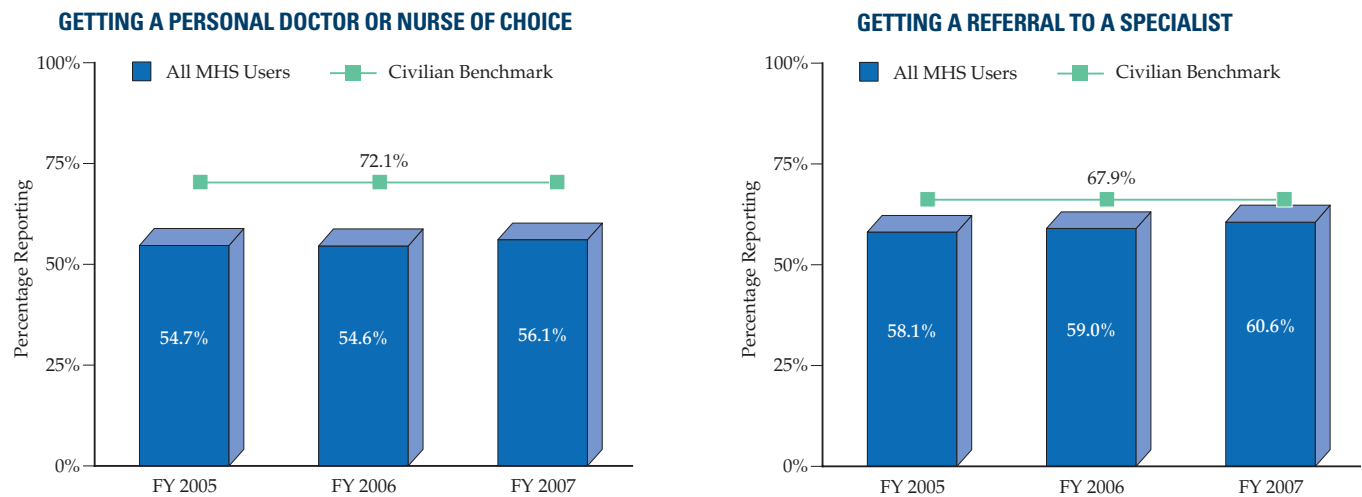
ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS (CONT'D)

Opportunity to Get a Health Provider of Choice

A major determinant of an individual's satisfaction with a health plan includes being able to access necessary providers. The graphs below depict MHS patient-reported satisfaction in (a) getting a personal doctor or nurse of one's choice, and (b) obtaining a referral to a specialty provider.

- For MHS users, satisfaction with the measure of access to personal doctors has remained stable between FY 2005 and FY 2007 (i.e., no statistically significant difference between years).
- MHS user satisfaction with obtaining a referral to a specialty provider increased by more than two percentage points between FY 2005 and FY 2007 (i.e., statistically different between each year).

TRENDS IN GETTING ACCESS TO PERSONAL OR SPECIALTY PROVIDERS



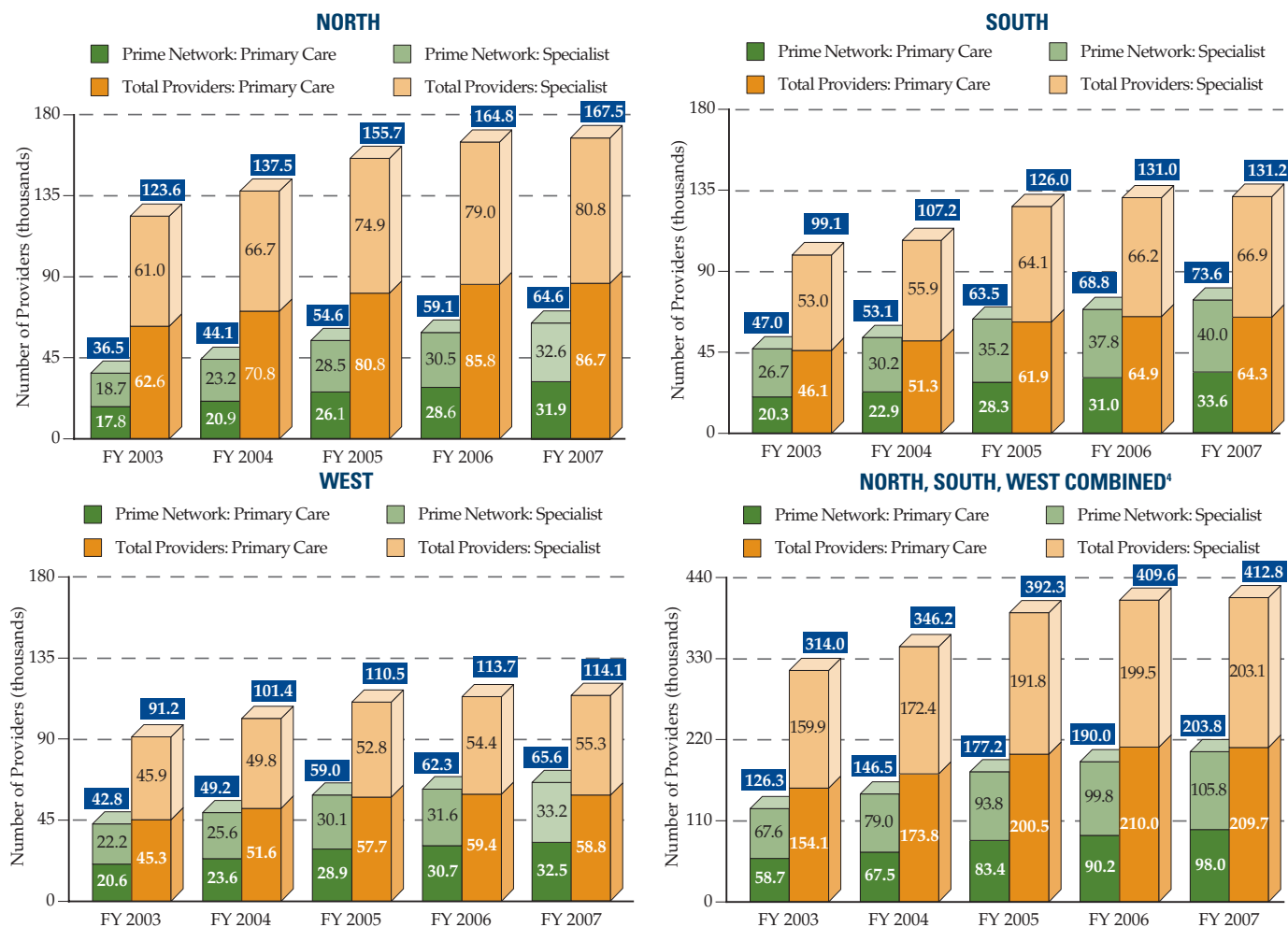
Note: DoD data were derived from the FYs 2005–2007 DoD Health Care Survey of DoD Beneficiaries (HCSDB) as of 11/27/2007 and adjusted for age and health status. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

TRICARE PROVIDER PARTICIPATION

Beneficiaries' satisfaction with access to care is influenced in part by the choice of providers available to them. The number of TRICARE participating providers was determined by the number of unique providers filing TRICARE (excluding TFL) claims.¹ After rising steadily from FY 2002 to FY 2005, the number of providers increased at a lower rate in FY 2006 and then leveled off in FY 2007. The trend has been evident for both Prime and Standard/Extra providers. Furthermore, as evidenced by the claims data, the numbers of primary care providers² and specialists have increased at about the same rate.

- The North Region saw the largest increase in the total number of TRICARE providers (36 percent), followed by the South Region (32 percent) and the West Region (25 percent).
- The North Region also saw the largest increase in the number of Prime network providers (77 percent), followed by the South Region (57 percent) and the West Region (53 percent).
- The total number of TRICARE providers increased by 1 percent in catchment areas and by 41 percent in noncatchment areas (not shown).³
- The number of Prime network providers increased by 22 percent in catchment areas and by 79 percent in noncatchment areas (not shown).

TRENDS IN PRIME NETWORK AND TOTAL PARTICIPATING PROVIDERS



Source: MHS administrative data, 1/21/2008

¹ Providers include physicians, physician assistants, nurse practitioners, and select other health professionals.

² Primary care providers were defined as General Practice, Family Practice, Internal Medicine, Obstetrics/Gynecology, Pediatrics, Physician's Assistant, Nurse Practitioner, and clinic or other group practice.

³ As noted on page 22, the catchment area concept is being replaced within the MHS by MTF Enrollment Areas.

⁴ Numbers may not sum to regional totals due to rounding.

Note: The source for the provider counts shown above was the TRICARE purchased care claims data for each of the years shown, where a provider was counted if he/she was listed as a TRICARE participating provider. In the case of Prime network providers, the counts were based on claims for Prime enrollees only where the provider produced at least 12 visits per year. The latter condition was added to reduce the possibility of counting out-of-network referrals.

SURVEY OF CIVILIAN PHYSICIAN ACCEPTANCE OF TRICARE STANDARD PATIENTS

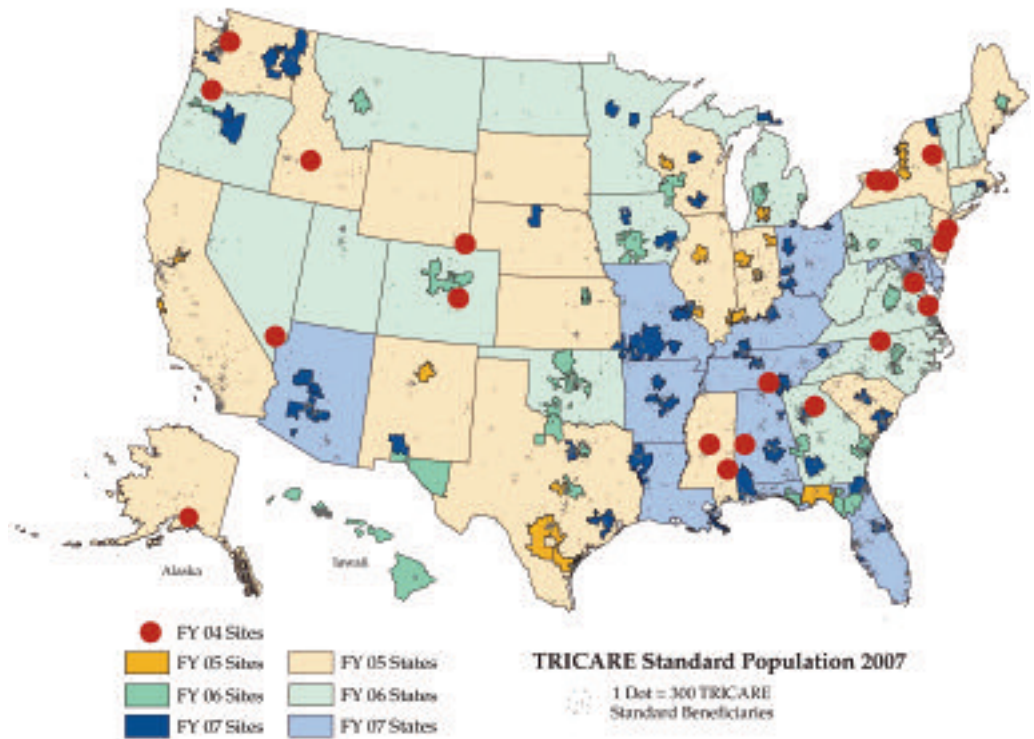
Purpose of Study

The Department has completed the final year of three planned annual surveys to determine civilian physician acceptance of new TRICARE Standard patients. The FY 2004 NDAA (Section 723) required the Department to “conduct surveys in the TRICARE market areas in the U.S. to determine how many health care providers are accepting new patients under TRICARE Standard in each such market area.” This legislation required DoD to survey at least 20 market areas each year, giving priority to those areas where representatives of TRICARE beneficiaries/providers identified locations experiencing significant levels of access-to-care problems under TRICARE Standard. Section 711, NDAA for FY 2006 provided additional questions to be included in the survey. Results for the previous years have been presented in earlier reports (2006 survey results in FY 2007 Report, p. 42; 2005 results in FY 2006 Report, pp. 62–64; 2004 results in FY 2005 Report, p. 49). Also, see “Civilian Physician Acceptance of New Patients Under TRICARE Standard,” at: <http://www.tricare.mil/ocfo/hpae/surveys.cfm>.

FY 2007 SURVEY RESULTS: More than 19,000 eligible physicians replied for an overall response rate of more than 50 percent. FY 2007 results are consistent with the results from the previous years:

- There appears to be a high level of physician awareness of the TRICARE program (9 of 10 doctors responding).
- There is a relatively high level acceptance of new TRICARE Standard patients (more than 8 of 10 doctors).
- 90 percent of those accepting new TRICARE Standard patients do so for all claims rather than on a claim-by-claim basis.
- Of the remaining 2 of 10 physicians who do not accept new TRICARE Standard patients, the most commonly cited reason is due to “reimbursement” (by one-fourth of the doctors’ comments, as well as one-fourth of their total comments, i.e., they may offer several reasons for not accepting).
- Between 8 and 9 of 10 physicians accepting Medicare also accept new TRICARE Standard patients.
- But, there is variability in these results, across hospital service areas (HSAs), across states, and among specialties reflecting opportunities for improving the general knowledge and acceptance of TRICARE.
- In FY 2007, almost 93 percent of all responding physicians (unweighted, in 53 HSAs) were aware of the TRICARE program, ranging from 77 percent to 100 percent; and 90 percent across 11 states (weighted, including HSA responses), ranging from 86 percent to 97 percent.
- The map below reflects where the MHS TRICARE Standard eligible population resides, as well as the states and submarket HSAs surveyed in FY 2007 (blue), FY 2006 (green), and FY 2005 (yellow). The baseline FY 2004 submarket survey sites are also shown (circles).

LOCATIONS OF DoD SURVEY OF CIVILIAN PHYSICIAN ACCEPTANCE OF NEW TRICARE STANDARD PATIENTS



Source: OASD(HA)/TMA-HPS&E, 11/19/2007

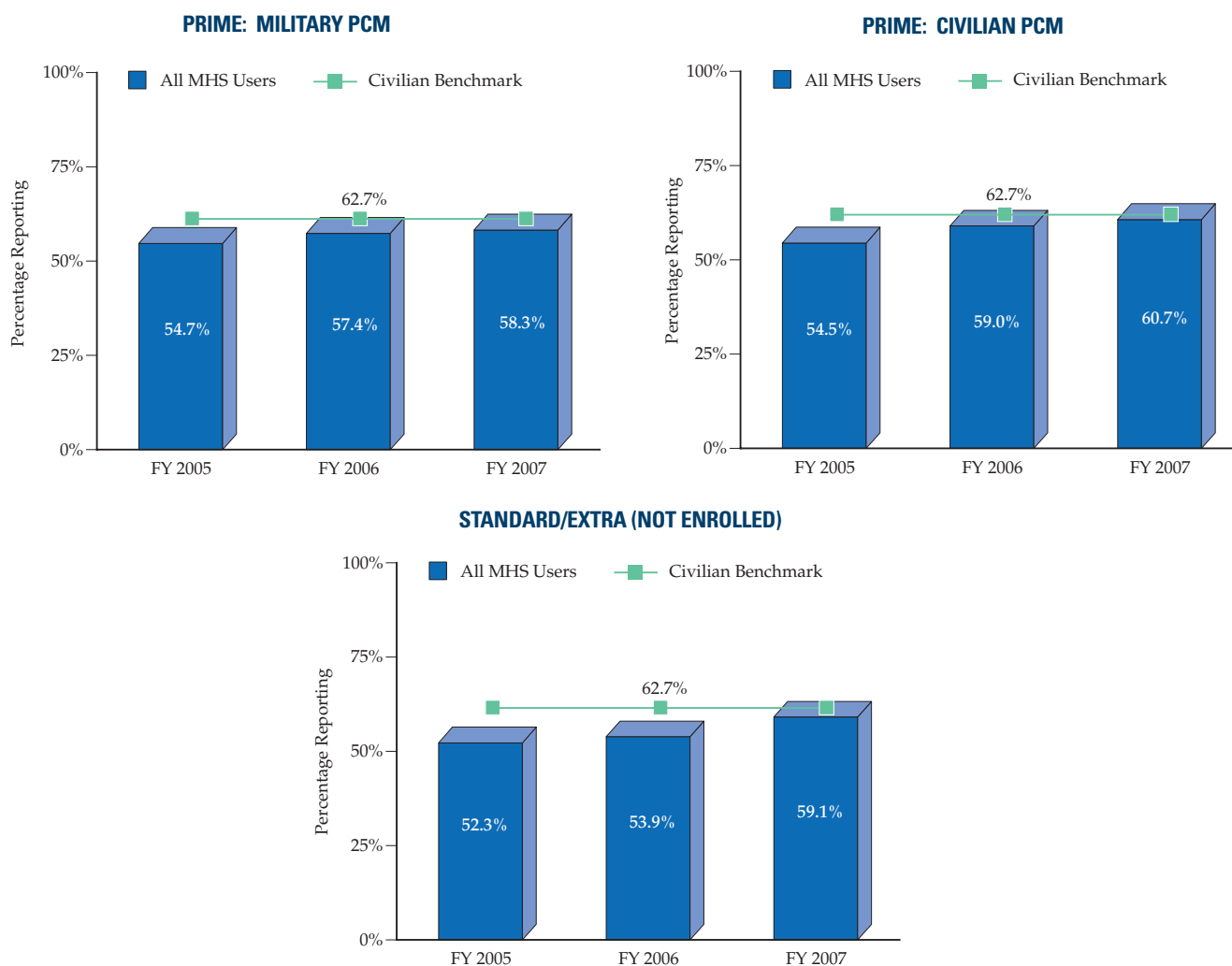
CUSTOMER SERVICE

Satisfaction with Customer Service

Access to, and understanding written materials about one's health plan are important determinants of overall satisfaction with the plan.

- MHS beneficiaries reported increased satisfaction with customer service in terms of understanding written materials, getting customer assistance, and dealing with paperwork between FY 2005 and FY 2007.
- MHS enrollees with civilian PCMs reported levels of satisfaction comparable to the civilian benchmark in FY 2007 (right chart below).
- MHS MTF enrollee and non-enrollee (users of Standard or Extra) satisfaction continued to lag the civilian benchmark.

TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE OF FINDING, UNDERSTANDING WRITTEN MATERIAL; GETTING CUSTOMER ASSISTANCE; & PAPERWORK



Note: DoD data were derived from the FYs 2005–2007 Health Care Survey of DoD Beneficiaries (HCSDb) as of 11/27/2007 and adjusted for age and health status. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDb methodology.

CLAIMS PROCESSING

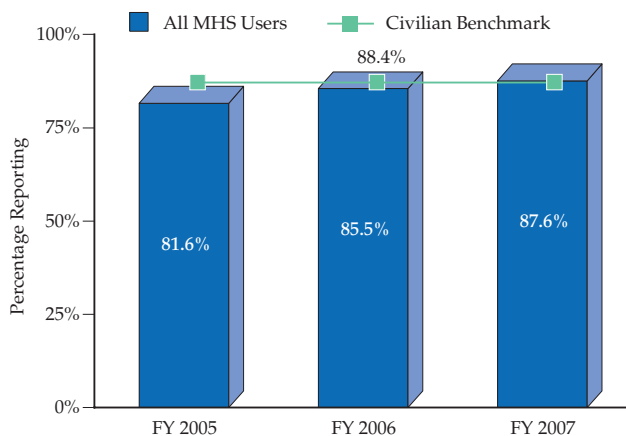
Claims processing is often cited as a “hot button” issue for beneficiaries as well as their providers. This is usually the case for both the promptness of processing, as well as the accuracy of claim and payment. The MHS monitors the performance of TRICARE claims processing through two means—surveys of beneficiary perceptions and administrative tracking through internal Government and support contract reports. This section reflects how MHS beneficiaries report their satisfaction with claims processing, and the next section reflects internal administrative monitoring.

Beneficiary Perceptions of Claims Filing Process

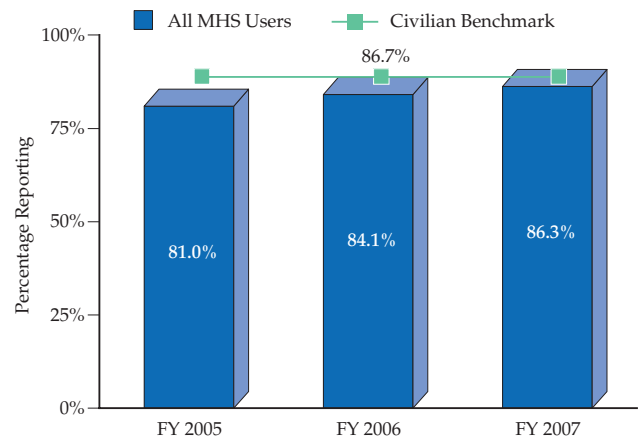
- Two primary measures of MHS beneficiary perceptions of claims processing increased between FY 2005 and FY 2007: Satisfaction with claims being processed accurately and satisfaction with processing in a reasonable period of time.
- While MHS satisfaction levels for both measures lagged the civilian benchmark from FY 2005 to FY 2006, they were at parity by FY 2007 (i.e., not statistically significantly different).
- While not shown, the processing of retained claims within 30 days exceeded the TRICARE performance standard of the past 6 years of 95 percent.

TRENDS IN SELF-REPORTED ASPECTS OF CLAIMS PROCESSING (ALL SOURCES OF CARE)

BENEFICIARY PERCEPTIONS OF CLAIMS ACCURACY



BENEFICIARY PERCEPTIONS OF CLAIM TIMELINESS



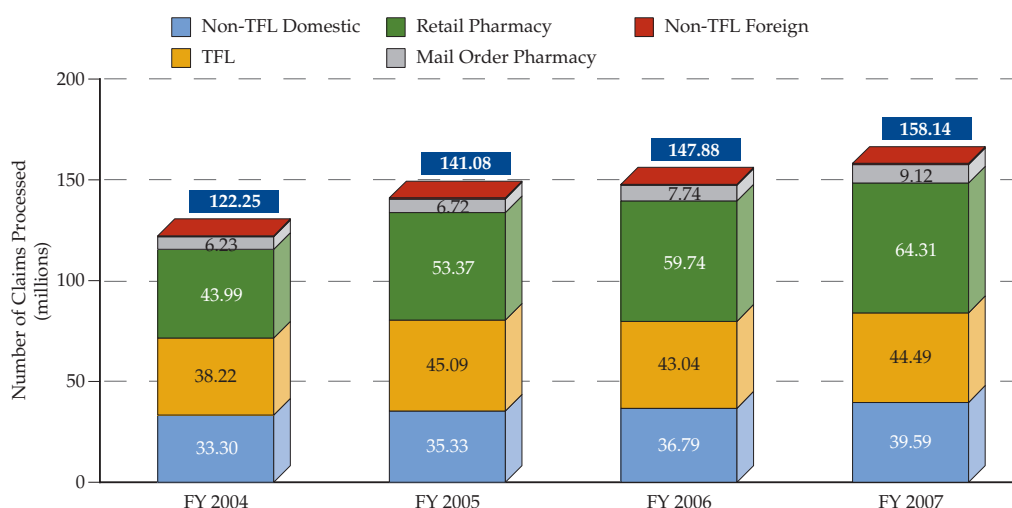
Note: DoD data were derived from the FYs 2005–2007 Health Care Survey of DoD Beneficiaries (HCSDB) as of 11/27/2007 and adjusted for age and health status. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

CLAIMS PROCESSING (CONT'D)

Administratively Reported Claims Filing by CONUS/TFL/OCONUS

The number of claims processed continues to increase, due to increases in purchased care workload, including claims from seniors for TFL, pharmacy and TRICARE dual eligible beneficiaries. Claims processing volume increased by almost one third (more than 29 percent) between FY 2004 and FY 2007 (7 percent alone from FY 2006 to FY 2007). This increase is due to a combination of an increase in the overall volume of claims as well as a change in how pharmacy claims are reported. Prior to FY 2005, a pharmacy claim could include multiple prescriptions, whereas beginning in FY 2005 individual pharmacy prescriptions were reported separately. Both retail and mail order prescriptions increased the fastest between FY 2004 and FY 2007 (36 percent and 20 percent, respectively).

TREND IN THE NUMBER OF TRICARE CLAIMS PROCESSED, FY 2005 TO FY 2007



Source: MHS and Support Contractor administrative data, 12/3/2007

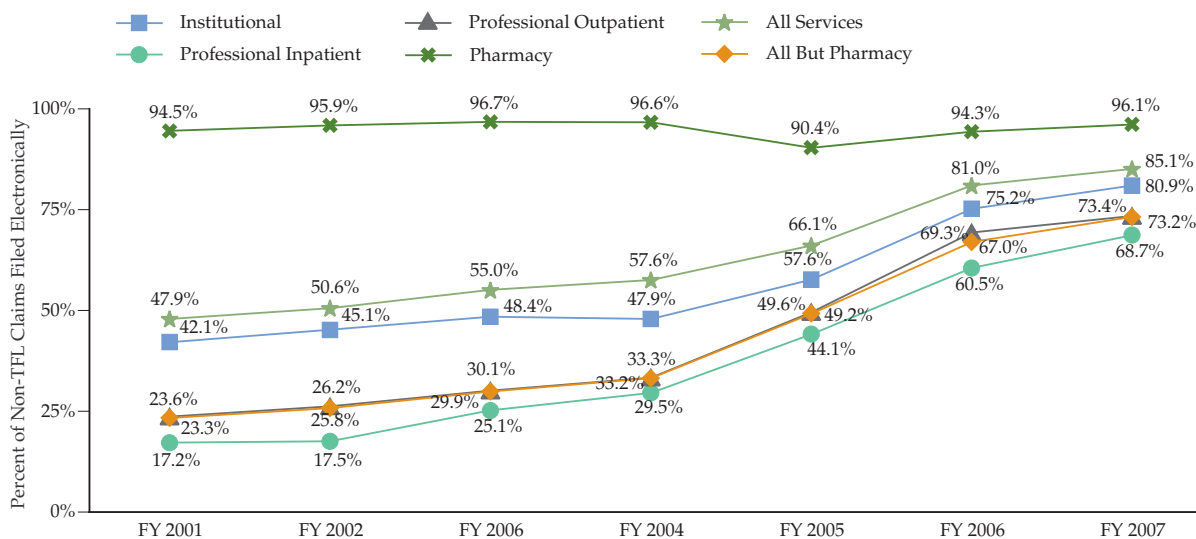
ELECTRONIC CLAIMS PROCESSING

Trends in Electronic Claims Filing

TRICARE continues to work with providers and claims processing contractors to increase processing of claims electronically, rather than in mailed, paper form. Electronic claims submissions use more efficient technology requiring less transit time between the provider and payer, are usually less prone to errors or challenges, and usually result in prompter payment to the provider. The TROs have been actively collaborating with the health care support contractors to improve the use of electronic claims processing.

- The percentage of non-TFL claims processed electronically for all services increased to more than 85 percent in FY 2007, up 4 percentage points from the previous year, and more than 27 percentage points since FY 2004.
- While pharmacy claims continue to be predominantly electronic, hovering at 95–96 percent, the real growth in electronic claims has been in the other categories reflected individually below, as well as in the “All but Pharmacy” trend line, surpassing 73 percent in 2007 (the individual categories below are: Institutional, and professional inpatient and outpatient services).
- TRICARE is a second payer to Medicare, and, as such, the TFL claims are predominantly electronic, irrespective of MHS involvement. While not shown, approximately 96 percent of all TFL claims and 94 percent of TFL nonpharmacy claims processed in FY 2007 were electronic, and that when included, the overall rate of electronic claims processed is 90 percent (vs. 85 percent for non-TFL claims).

EFFICIENCY OF PROCESSING TRICARE CLAIMS: PERCENTAGE OF NON-TFL CLAIMS FILED ELECTRONICALLY



Source: MHS administrative claims data, 12/3/2007

Note: Efforts to increase pharmacy access through the mail order program beginning in mid FY 2007 may ultimately change the overall percentage of claims processed electronically. This is because mail order scripts cover longer periods of time (90 days for mail order instead of 30 days at retail pharmacies), which will be reflected in fewer refill scripts per person, all other factors being equal. As such, the mix of Pharmacy vs. other claims will also likely change which will skew the composite numbers in the future.

ACUTE MYOCARDIAL INFARCTION MEASURES—PROCESS AND OUTCOMES COMPARISON: MILITARY AND CIVILIAN HOSPITALS REPORTING TO THE JOINT COMMISSION (FY 2003–FY 2007)

In the United States, the Joint Commission is the nationally recognized organization that surveys health care settings using pre-established, published criteria to determine the accreditation status based on a triennial on-site survey by health care professionals. Participation in the Joint Commission survey process has been an institutionalized aspect of quality in the MHS for over two decades. The Joint Commission has established the ORYX® Core Measures initiative to incorporate the use of data for comparative analyses and public reporting as a method to enhance the quality improvement activities in accredited health care organizations. Additionally, the Joint Commission and the Centers for Medicare and Medicaid Services have collaborated through the Hospital Quality Alliance to align measures across the health care industry. All of the hospital quality measures recommended by the alliance are endorsed by the National Quality Forum. These measures have been designed to permit more rigorous comparisons using standardized, evidence-based measures and data gathering procedures.

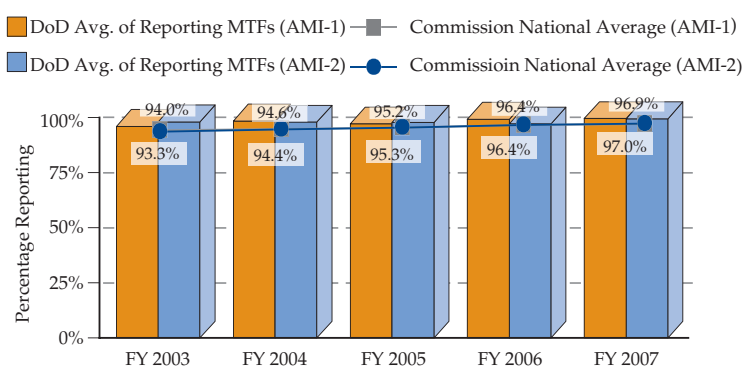
The Joint Commission has identified key measures with respect to acute myocardial infarction (AMI), heart failure, pneumonia, pregnancy and surgical care improvement project. MHS MTFs are currently reporting data on several of the Commission's core measure sets. The charts below provide a sample of a few of the measures focusing on key aspects for managing the effects of AMI, with respect to the provision of aspirin within 24 hours of arrival at the hospital, aspirin prescription upon discharge, and counseling to quit smoking. The annual results of MHS-reporting hospitals are compared to the national average of accredited U.S. institutions reported by the Commission for that Fiscal Year.

- As shown on the left-hand chart below, MHS MTFs have maintained a high rate of aspirin therapy for AMI patients, exceeding the Commission's comparative national average over the last five Fiscal Years.
- As shown on the right-hand chart below, while MHS documentation of smoking cessation counseling for those adults admitted for AMI has improved between FY 2003 and FY 2007, it remains below the national

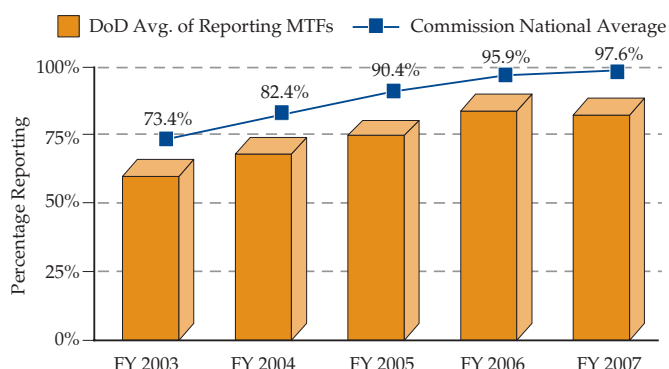
average reported by the Commission which has similarly improved over that time frame.

- As shown in the bottom-most chart, with respect to outcomes of the AMI care process, the MHS-reported inpatient mortality rate has declined between FY 2003 and FY 2007, remaining below the Commission's national average of reporting hospitals.

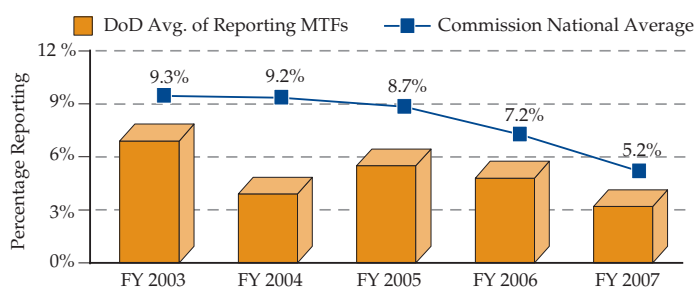
AMI: ASPIRIN ARRIVAL AND DISCHARGE



AMI: SMOKING COUNSELING



AMI: RELATED INPATIENT MORTALITY



SPECIAL STUDY: COLORECTAL CANCER SCREENING

Background: Colorectal cancer is the second leading cancer-related cause of death in the United States. More than 50,000 die each year of colon or rectal cancer. Several different methods of detection are recommended, in order of increasing definitiveness, cost, and invasiveness: Fecal occult blood testing (FOB), sigmoidoscopy, and colonoscopy. In March 2006, TRICARE benefits were extended to include colonoscopies every 10 years. TRICARE also covers annual FOB and sigmoidoscopy every three to five years. Most civilian plans offer similar benefits, and some states have mandated coverage of screening colonoscopies.

Purpose: The purpose of this study was to establish if there is evidence of improved access to colorectal cancer screening among MHS beneficiaries since the enrichment of the TRICARE benefit in March 2006.

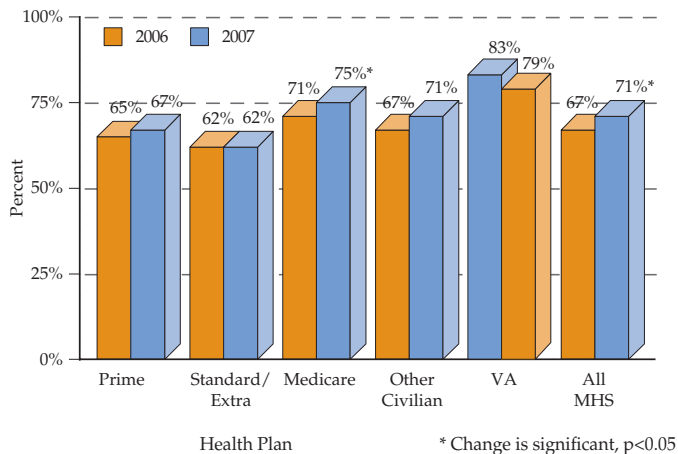
Design: The Health Care Survey of DoD Beneficiaries (HCSDB) is a survey of a sample of TRICARE eligibles and is conducted on a quarterly basis to measure access to, and satisfaction with, health care. Shortly before March 2006, and most recently in July 2007, the HCSDB devoted a battery of questions concerning access to preventive care among MHS eligibles. Access to colon cancer screening was among those items in both surveys.

Results: Self-Reported Screening Rates Have Increased

Across all MHS health plans, compliance with American Cancer Society (ACS) screening guidelines in 2007 is the same or greater than compliance in 2006. Overall, compliance has risen from 67 percent to 71 percent (below, chart on left for “All MHS”).

The increase in reported colonoscopy extends to all TRICARE beneficiaries. Active Duty screening rates have risen substantially, though Active Duty make up only a small part of the population age 50 and older. Their compliance with ACS guidelines has risen from 53 percent to 71 percent (below, table on right). The increase is due primarily to colonoscopy, which has risen from 42 percent to 64 percent.

COMPLIANCE WITH ACS GUIDELINES BY HEALTH PLAN



SCREENING BY BENEFICIARY CATEGORY

	ACS Compliant		FOB within 2 years		Colonoscopy within 10 years	
	2006	2007	2006	2007	2006	2007
Active Duty	53%	71%*	24%	29%	42%	64%*
ADFM's	50	56	22	19	44	51
Retirees Under Age 65	65	68	33	29*	54	60*
Retirees Over Age 65	69%	75%*	34%	31%	60%	68%*

* Change is significant, $p < 0.05$

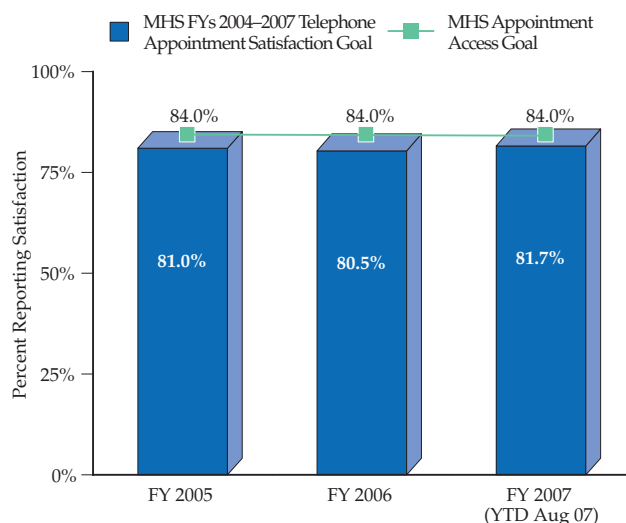
Source: the Center for Health Care Management Studies, TMA and Mathematica Policy Research, October 2007

Conclusions: Results from the HCSDB indicate that overall compliance with guidelines for colon cancer screening has improved among TRICARE beneficiaries in the past year. The improvement is due to an increase in colonoscopy. This shift has occurred across health plans, beneficiary groups, and usual sources of care.

APPOINTMENT ACCESS IN THE DIRECT CARE SYSTEM

The MHS is concerned about beneficiary satisfaction with telephone access to the direct care system in addition to the satisfaction metrics presented previously (External Customers: Satisfaction with the health plan and care overall, as well as the primary care and specialty care physicians). This metric is designed to put MHS patients at the center of attention in the direct care system.

SATISFACTION WITH DIRECT CARE ENCOUNTER (DIRECT CARE TELEPHONE APPOINTMENT)



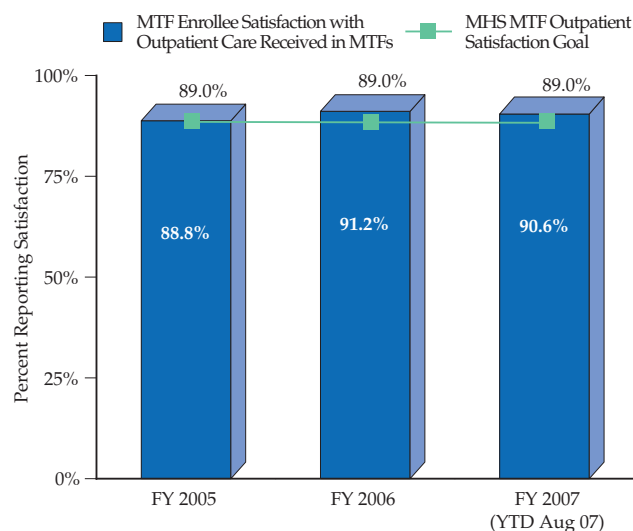
The MHS goal was raised in FY 2004 to 84 percent from 82 percent the previous year, when patients reporting satisfaction (83 percent) exceeded the 82 percent goal in FY 2003. The level of satisfaction reported by MHS beneficiaries has remained stable from FY 2004 (not shown) to FY 2007, hovering at 81 percent and not meeting the revised goal of 84 percent.

Source: DHP Performance Contract, Satisfaction with Access; reported in the Annual Defense Review (SECDEF Instrument Panel), 11/30/2007

SATISFACTION WITH CARE RECEIVED IN THE DIRECT CARE SYSTEM

The MHS is concerned about beneficiary satisfaction with the actual encounter in the MTF. Similar to measuring beneficiary access to MTFs via telephone, this metric is designed to put MHS patients at the center of attention in the direct care system. Patient satisfaction here is measured by a survey following a specific clinic visit.

SATISFACTION WITH DIRECT CARE ENCOUNTER – ACCESS



The percentage of beneficiaries reporting satisfaction with the care received within MTFs in the past three years has increased by more than 2 percent, and has exceeded the MHS goal of at least 89 percent satisfaction over the past two years.

Source: DHP Performance Contract, Satisfaction with Access; reported in the Annual Defense Review (SECDEF Instrument Panel), 11/30/2007

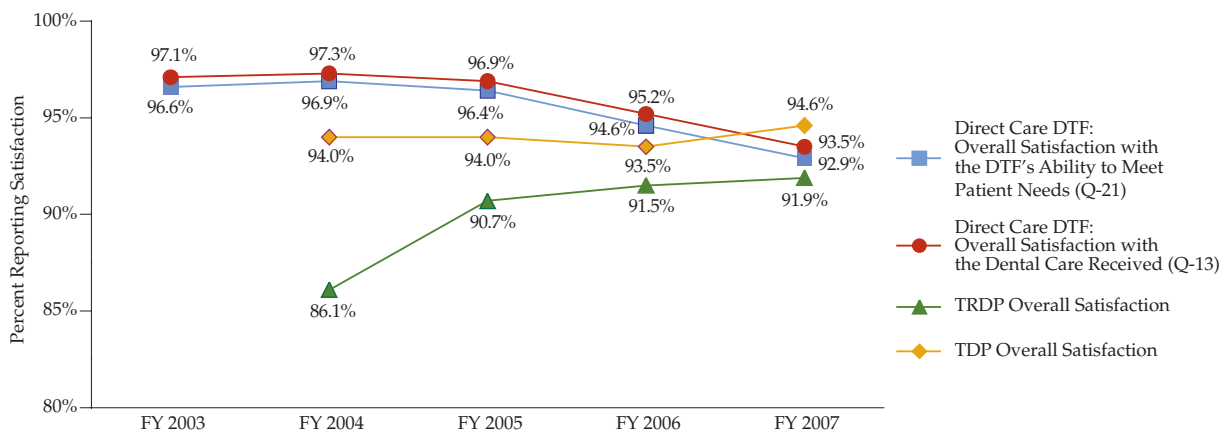
TRICARE DENTAL PROGRAMS CUSTOMER SATISFACTION

Dental Customer Satisfaction

The overall TRICARE dental benefit is comprised of several delivery programs serving the MHS beneficiary population. Consistent with other benefit programs, beneficiary satisfaction is routinely measured for each of these important dental programs.

- Satisfaction with dental care reported by patients receiving dental care in military dental treatment facilities (DTFs) was almost 93 percent in FY 2007, compared with 94.6 percent in FY 2006. DTFs are responsible for the dental care of about 1.8 million Active Duty Service Members, as well as eligible Outside Continental United States family members. During FY 2007, the Tri-Service Center for Oral Health Studies collected more than 264,000 DoD Dental Patient Satisfaction Surveys from patients who received dental care at the Services' DTFs, an 81 percent increase over FY 2006's 146,000. The overall DoD dental patient satisfaction with the ability of the DTFs to meet their dental needs decreased to 93.5 percent in FY 2007.
- The **TDP FY 2007 composite average enrollee satisfaction increased to 94.6 percent**, from 93.5 percent in FY 2006. The TDP is a voluntary, premium-sharing dental insurance program that is available to eligible ADFMs, Selected Reserve and Individual Ready Reserve members, and their family members. As of September 30, 2007, the TDP services 738,838 contracts covering 1,790,196 lives. While not shown, this measure includes satisfaction ratings for network access (94 percent), provider network size and quality (92 percent), claims processing (96.6 percent), enrollment processing (96.3 percent), and written and telephonic inquiries (94 percent).
- The **TRDP overall retired enrollee satisfaction rates increased to 91.9 percent** in FY 2007, from 91.5 percent in FY 2006. The TRDP is a full premium insurance program open to retired Uniformed Service members and their families. The TRDP enrolled more than a million covered lives in FY 2007, a 5.9 percent increase from FY 2006, ending the year with 488,257 contracts serving 1,033,186 lives.

SATISFACTION WITH TDPs: DTF AND CONTRACT SOURCES



Source: TRICARE Operations Division and Tri-Service Center for Oral Health Studies for direct care (DTF) survey data (Dental Patient Satisfaction reporting Web site Trending Reports) and the respective Dental Support Contractors for TDP and TRDP survey data. Data as of 11/20/2007.

Note: The three dental satisfaction surveys (direct care, TDP and TRDP) are displayed above for ease of reference, but are not directly comparable because they are based on different survey instruments and methodologies.

DEPLOYABLE MEDICAL CAPABILITY

To meet the needs of operational commanders, we must be able to deploy anywhere, anytime with flexibility, interoperability, and agility. Again, this capability is dependent on globally accessible health information and rapid development and deployment of innovative medical services and products. Since we support the full range of military operations, we must be ready to assist in civil support and homeland defense operations such as disaster relief and management of pandemic flu.



MHS efforts will ensure future medical support is fully aligned with joint force health protection, and enable rapid response to the needs of a changing national security environment. Current military strategies mandate that the medical force structure be joint, agile, and interoperable to ensure optimal responsiveness in diverse operations.

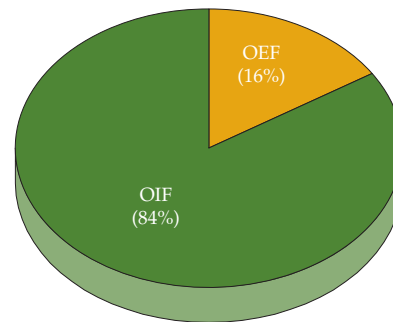
As reflected in the graphic above, components of our deployable medical capability include:

- **First Responder Care** is the ability to provide initial medical care at or near the point of injury by the individual, medical and/or non-medical personnel. This may include preparing the casualty for transportation to the next medical capability as required.
- **Essential Care (Forward Resuscitative Care)** is the ability to provide capabilities required by medical personnel to salvage life, limb, or eyesight and to relieve pain.
- **Definitive Care In-Theater (Theater Hospitalization)** is the ability to provide capabilities required by medical personnel to repair, restore, stabilize, or rehabilitate casualties within the theater. These include preparation for strategic transport, return to duty, or processes for rehabilitation, as appropriate. This includes the utilization of telemedicine in this setting as a force multiplier.
- **En Route Care** is the ability to provide a systematic evacuation capability of critically injured/ill patients accompanied by trained medical providers from one medical capability level to another.
- **Patient Movement Within a Joint Operational Area (JOA) (Intra-Theater)** is the ability to conduct the efficient joint movement of patients to appropriate levels of care. Effective patient regulation and transport ensures that troops receive definitive care quickly and at the appropriate level. Those troops with less severe injuries/conditions are returned to duty in minimal time, while those with injuries or illnesses exceeding local capabilities are safely transported to higher levels of care, thus reducing mortality rates and setting the stage for the best possible long-term outcome, i.e., final level of function.

DEPLOYABLE MEDICAL CAPABILITY (CONT'D)

- **Patient Movement Outside of a JOA (Inter-Theater)** is the ability to conduct effective coordination and movement from a JOA to an appropriate definitive care facility (with en route care provided). Critical patients must be rapidly identified for replacement in the JOA. These processes allow commanders to project forces more accurately and maintain maximum troop strength where needed.
- **Joint Medical Logistics and Infrastructure Support (JMLIS)** is the ability to work in conjunction with Service force management and force design organizations to ensure the medical supplies, material, and equipment with which our medical forces deploy include the latest technologies and advances in the medical field. It also ensures medical supplies, material, and equipment are delivered to the right person, at the right place, at the right time.
- **Joint Theater Medical Command and Control (JTMC2)** is the ability to leverage the concurrent transformation of joint and Service education and training, joint medical logistics in enterprise-wide support, common information management, information technology, operating architectures, and environments. Joint medical information systems must be fully networked and interoperable among Services (line and medical) at the tactical and operational levels.
- Patients transported via aeromedical evacuation out of operational theaters included the following, and, as shown in the pie chart, those transported out of the Operation Iraqi Freedom represent the majority of patient movement:
 - Operation Enduring Freedom (OEF)
 - Afghanistan
 - Philippines
 - Horn of Africa
 - Trans Sahara
 - Pankisi Gorge (Rep. of Georgia)
 - Operation Iraqi Freedom (OIF)
 - Includes some areas outside Iraq, such as Kuwait

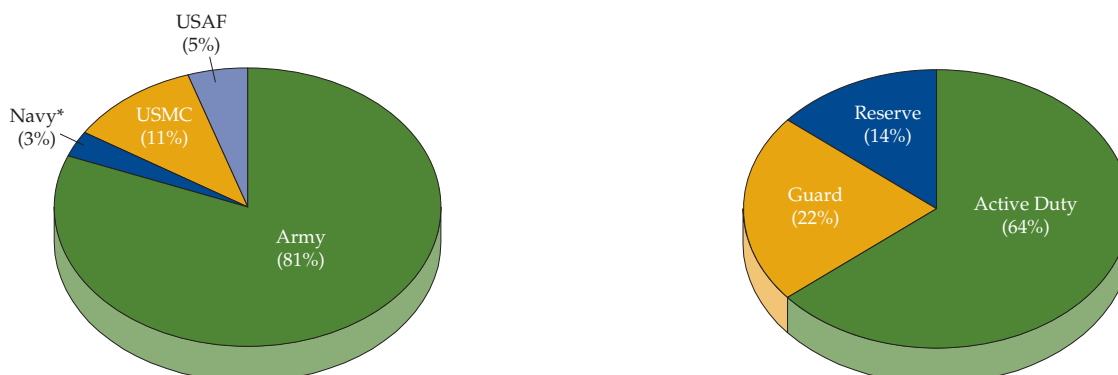
MEDICAL AIR TRANSPORTS BY THEATER OF OPERATION



Source : U.S. Transportation Command Regulating And Command & Control Evacuation System (TRAC2ES) as of December 31, 2007

- These medical air patient movements by military Service & Component reflect the general deployment of the forces, with Army representing more than 80 percent, and the Active Duty nearly two-thirds of the patient load.

MEDICAL AIR PATIENT MOVEMENTS BY MILITARY SERVICE & COMPONENT

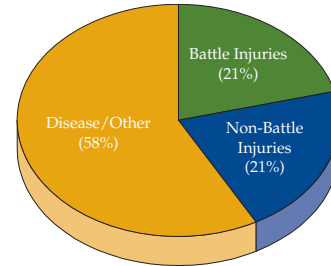


Sources : TRAC2ES, as of December 31, 2007, and the Contingency Tracking System (CTS), as of October 31, 2007

DEPLOYABLE MEDICAL CAPABILITY (CONT'D)

- Since October 1, 2001, a total of 46,751 medical air transports were provided, with disease and other conditions representing almost 60 percent of the movement, and the rest equally split between battle injuries and non-battle injuries (each about one-fifth of total air transport movement).
 - These cases cover a wide range of conditions and severity: Back problems, chest symptoms, mental health concerns, kidney stones, hernias, etc.
- **Evacuation out of theater is usually to Landstuhl Army Regional Medical Center (LARMC), Germany.** The most common MTF destinations after LARMC have been:
 - Walter Reed Army Medical Center, DC (20 percent)
 - Eisenhower Army Medical Center, Ft. Gordon (8 percent)
 - National Naval Medical Center, Bethesda (5 percent)
 - Brooke Army Medical Center, Ft. Sam Houston (7 percent)
 - Womack Army Medical Center, Ft. Bragg (6 percent)
- These locations are determined on a case-by-case basis, with the decision considering:
 - Best available specialty care for the specific injury or illness
 - Proximity to home/family
 - Proximity to military unit

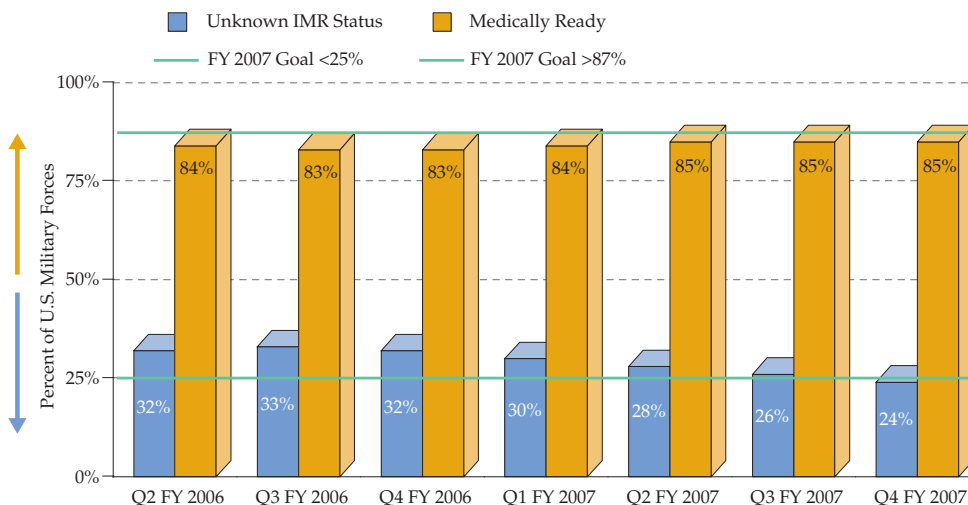
MEDICAL AIR TRANSPORTS



Source : U.S. Transportation Command Regulating And Command & Control Evacuation System (TRAC2ES) as of December 31, 2007

The DoD's deployment health program offers full-spectrum coverage by including prevention measures during the actual deployment as well as supporting medical activities before and after the deployment. A cornerstone to the deployment health program is our individual medical readiness program (IMR). The IMR helps commanders to ensure that our forces are always medically ready to deploy. As can be seen in the chart below (Total Force—Reserve and Active Components combined), Individual Medical Readiness (IMR), IMR improved between 2006 and 2007. The "Medically Ready" status increased from 84 to 85 percent, missing the goal of greater than 87 percent. The "Unknown Status" decreased from 32 percent to 24 percent, surpassing the goal of less than 25 percent.

TOTAL FORCE (RESERVE AND ACTIVE COMPONENTS COMBINED) INDIVIDUAL MEDICAL READINESS (IMR)—USD(P&R) PERFORMANCE MEASURE



Unknown Status = overdue periodic (annual) health or dental assessment.

Medically Ready = those with known IMR status, i.e., excludes Unknown status from denominator, who are either fully medically ready or partially ready (deficiencies are correctable prior to deployment).

Source: Service and HA/FHP&R administrative data as of Jan 14, 2008

DEPLOYABLE MEDICAL CAPABILITY (CONT'D)

Comprehensive health surveillance for deployments includes both medical surveillance and occupational and environmental health surveillance:

Medical surveillance relies on the integration of a number of systems to enhance the DoD's ability to identify emerging health threats in the deployed setting to limit or prevent acute or chronic diseases, injury, or death in our personnel. It also permits an assessment of the efficacy of force health protection measures currently in place. Primary components include:

- **Disease and Injury (D&I) Surveillance.** The specific objectives of D&I include detecting outbreaks of infectious diseases at the earliest point possible, identifying sentinel medical events (high-risk events, such as a case of smallpox, anthrax, malaria, etc.), and all other relevant areas of public health and preventive medicine, such as injury prevention. Public health professionals monitor health event trends, both inpatient and outpatient, in near-real-time using the Joint Medical Work Station (JMeWS, a component of the Theater Medical Information Program). This system analyzes data using biostatistical methods and produces graphs and tables to assist the local staff. Regional and reach-back consultants also have access and provide back-up support to the deployed personnel.
- **Laboratory-based Surveillance.** For example, the DoD Global Influenza Surveillance Program includes sentinel sites in active combat theaters, collecting and analyzing specimens to identify the appearance of new strains, e.g., avian influenza. A variety of pathogen detection capabilities exist throughout the theater, including rapid PCR tests and other laboratory methods. For validation, referral laboratories are available at the DoD overseas medical research units, at OCONUS regional medical centers like Landstuhl and Tripler, and at CONUS research labs like the Air Force Institute for Operational Health and the Naval Health Research Center. The Global Emerging Infections Surveillance and Response System (GEIS) coordinates many of the activities in support of deployed operations and the relevant combatant command.
- **Miscellaneous Public Health Activities.** These cover a broad range, such as inspecting food and water sources, food handling and preparation, monitoring disease vectors (e.g., sand flies and mosquitoes), and assessing the availability and proper use of personal protective equipment.

Occupational and environmental health surveillance is conducted as directed by Department of Defense Instruction 6490.03. All OEH monitoring data is identified, documented, and archived in a systematic manner, as follows:

- Area and date-specific environmental monitoring summaries are being developed by the Services to document environmental conditions potentially affecting health, and also to serve as means to inform health care providers of those environmental conditions and possible health risks associated with the conditions.
- Environmental samples are identified with a date, time, and location that can be linked with individual personnel who were at a particular location at a specified date and time in order to establish potential environmental exposures to personnel.
- Possible hazardous exposure incidents are thoroughly investigated, extensive environmental monitoring accomplished, appropriate medical tests ordered, and rosters of exposed personnel assembled. Medical records entries are made to document any exposures.

DEPLOYABLE MEDICAL CAPABILITY (CONT'D)

U.S. Army Center for Health Promotion and Preventive Medicine laboratories have analyzed more than 6,500 air, water, and soil samples in support of OIF and OEF. These samples were taken at more than 275 locations in Iraq, Afghanistan, several locations in Kuwait, and other neighboring countries. An environmental sampling summary for the first six months of 2007 is included below.





TREND IN ENROLLMENT IN TRICARE RESERVE SELECT (TIER 1, OPERATIONAL SINCE JULY 2005)






OEF/OIF Monitoring Summary

January 1, 2007, to June 30, 2007



Media	# of Sites Sampled	# of Samples	Health Risk	Comments
Air	47	473	 Moderate	Sand and dust exceed guidelines, but pose minimal acute health effects; long-term effects not known
Water Treated	74	140	 Moderate	Moderate health effects possible, but in most cases would require consumption of a water source for prolonged periods of time
Water Untreated	62	94	 Moderate	Moderate health effects possible, but untreated water is not likely to be consumed
Soil	64	175	 Low	Generally not enough exposure to soil to cause adverse health effects by a contaminant

Key: Risk Assessment of Health Effects

High		Death, incapacitating, or irreversible acute, latent or chronic illness (e.g., severe eye irritation or blurred vision, severe dizziness or confusion, seizures, cancer, or effects on critical organs or organ systems), or severe disability.
Moderate		Minor to moderate acute illness or disability (e.g., gastrointestinal symptoms such as vomiting or diarrhea), or chronic, or delayed-onset of illness or illness that results in long-term health effects.
Low		No health effects or very minor/transient illness expected (e.g., skin irritation, respiratory allergies, nausea, headache, dermatitis).

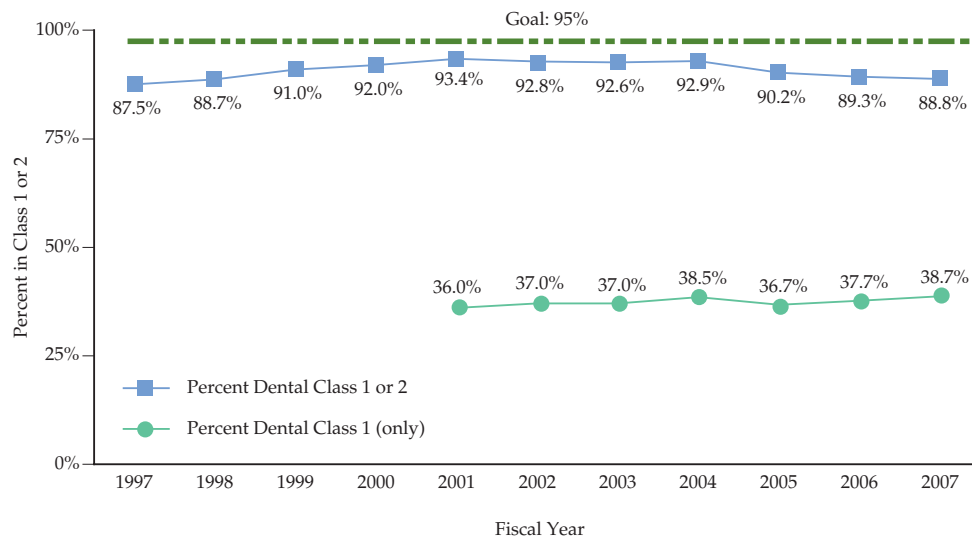
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we: (1) Maintain the worldwide deployment capability of our Service members, as in dental readiness; (2) assess how well we support our Wounded Warriors as they go through the recovery, rehabilitation, and reintegration process; and (3) measure the success of benefits programs designed to support the Reserve Component forces and their families, such as in TRICARE Reserve Select.

DENTAL READINESS

The MHS Dental Corps Chiefs established in 1996 the goal of maintaining at least 95 percent of all Active Duty personnel in Dental Class 1 or 2. Patients in Dental Class 1 or 2 have a current dental examination, and do not require dental treatment (Class 1) or require non-urgent dental treatment or re-evaluation for oral conditions that are unlikely to result in dental emergencies within 12 months (Class 2—see note below chart). This goal also provides a measure of Active Duty access to necessary dental services. Overall, the percentage of patients in Dental Class 1 or 2 has been stable over the past 10 years, from FY 1997 to FY 2007 as shown below:

- Overall MHS dental readiness in the combined Classes 1 and 2 remains high. However, while the gap between MHS performance and the 95 percent target rate for dental readiness in Classes 1 and 2 was almost achieved in FY 2001, it remains elusive. The FY 2007 rate of 88.8 percent reflects a half-percent decrease from FY 2006.
- The rate for Active Duty personnel in Dental Class 1 increased by 1 percent to 38.7 percent in FY 2007.

TREND IN ENROLLMENT IN TRICARE RESERVE SELECT (TIER 1, OPERATIONAL SINCE JULY 2005)



Source: The Services' Dental Corps—DoD Dental Readiness Classifications.

Dental Class 1: (Dental Health or Wellness): Patients with a current dental examination, who do not require dental treatment or re-evaluation. Class 1 patients are world-wide deployable.

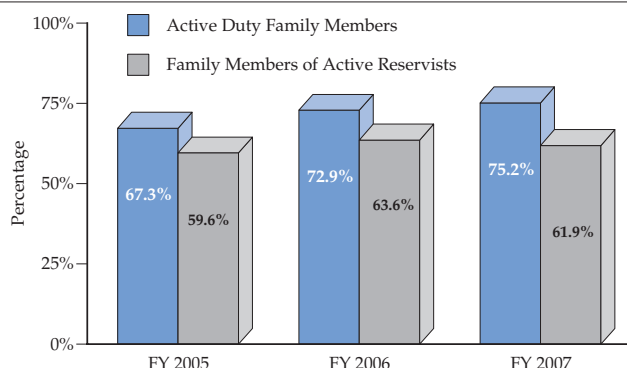
Dental Class 2: Patients with a current dental examination, who require nonurgent dental treatment or re-evaluation for oral conditions, which are unlikely to result in dental emergencies within 12 months. Patients in Dental Class 2 are worldwide deployable.

SPECIAL STUDY: COMPARISON OF RESERVE AND ACTIVE COMPONENT FAMILY MEMBER ACCESS TO ROUTINE CARE INFORMATION

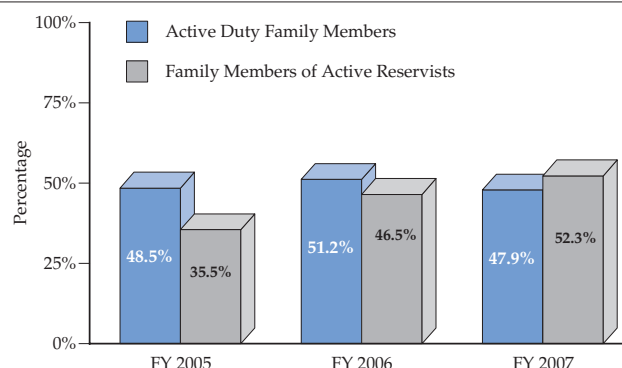
A special study completed in FY 2007 sought to identify if there were differences in access to customer service, supportive information services, and problems with health plan paperwork between family members of Active National Guard and Reserves (Reserve Component, RC) and family members of Active Component personnel. The adult HCSDB is designed to measure a number of health care-related factors from samples of eligible MHS beneficiaries. The survey includes core questions from the CAHPS used by many of the nation's civilian health plans. This special study re-examined survey data previously collected during FY 2007 from eligible beneficiaries through random sampling.

- **Problems with Paperwork:** The first chart shows that Active RC family members (Family Members of Active Reservists) are significantly more likely than Active Component family members (ACFM) to report they have experienced problems with health plan paperwork in the past year. The results indicate that while paperwork problems of the ACFM have improved in the past three years, problems for RC family members have not.
- **Access to Information:** Access to, and understanding of, written materials about one's health plan are important to overcoming paperwork problems. In FY 2005, enrolled RC family members were more likely than active component members to report they encountered problems in obtaining needed information in writing or over the Internet. However, the proportion of RC with problems accessing information has fallen significantly since FY 2005, and did not differ significantly from the Active Component rate in FY 2006 or FY 2007.
- **Access to Customer Service:** Access to customer service help is also important to beneficiaries navigating a new health plan or experiencing paperwork problems. Problems of both Active Component and RC family members in getting needed help from customer service have fallen significantly between FY 2005 and FY 2007.

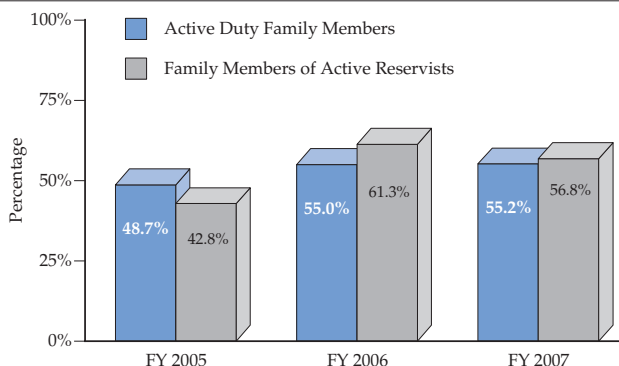
NO PROBLEM WITH PAPERWORK: ACTIVE DUTY AND RESERVIST FAMILY MEMBERS



NO PROBLEM GETTING INFORMATION: ACTIVE DUTY AND RESERVIST FAMILY MEMBERS



NO PROBLEM GETTING CUSTOMER SERVICE: ACTIVE DUTY AND RESERVIST FAMILY MEMBERS



Note: TRICARE users. ADFM excludes FM of Reservists.

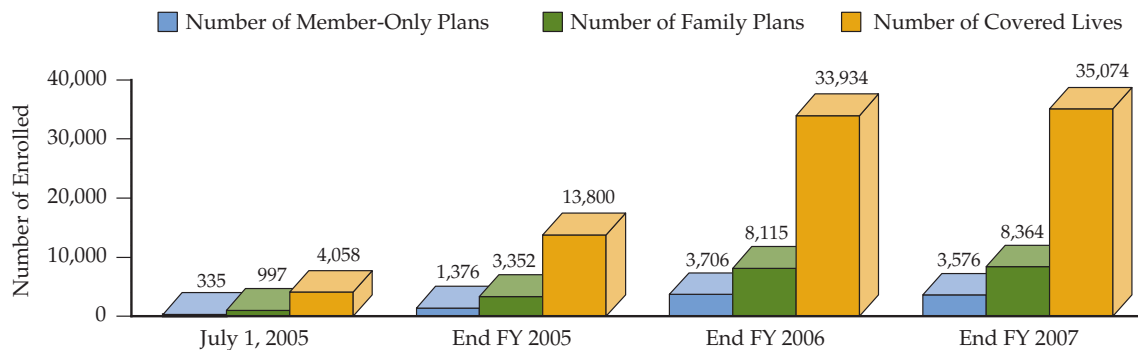
SPECIAL STUDY: IMPACT OF TRICARE RESERVE SELECT (TRS) BENEFITS PROGRAM

Since September 11, 2001, the DoD has expanded access to TRICARE for qualified National Guard and Reservists and their families. TRS, authorized by 10 U.S.C. 1076(b) and 1076(d), was established for the purpose of offering TRICARE Standard and Extra health coverage to qualified members of the Selected Reserve and their immediate family members (*Federal Register*, June 21, 2006). TRS is the premium-based TRICARE health plan offered for purchase by certain members and former members of the RC and their families. Originally, Reserve members were eligible for TRS (Tier 1) coverage if they were called or ordered to Active Duty, under Title 10, in support of a contingency operation on or after September 11, 2001. RC members and their respective Reserve units must agree for the member to stay in the Select Reserve for one or more years to qualify. TRS coverage must be purchased, with TRS members paying a monthly premium for health care coverage (for self

only or for self and family). The NDAA for FY 2006 added two more premium tiers, while the NDAA for FY 2007 restructured the program to a simpler single-tier health plan (ref FY 2007 report, page 7, and page 9 of this report). The program offers comprehensive health care coverage similar to TRICARE Standard and TRICARE Extra. Members access care by making appointments with any TRICARE authorized provider, hospital, or pharmacy, network or non-network. TRS members may also access care at an MTF on a space-available basis. Pharmacy coverage is available from an MTF pharmacy, TMOP, and TRICARE network and non-network retail pharmacies. Program options were expanded in FY 2006 across three tiers, for different premiums.

By the end of the program's third complete year, enrollment in TRS reached more than 35,000 covered lives in more than 3,500 member-only plans and more than 8,300 family plans.

NO PROBLEM GETTING INFORMATION: ACTIVE DUTY AND RESERVIST FAMILY MEMBERS



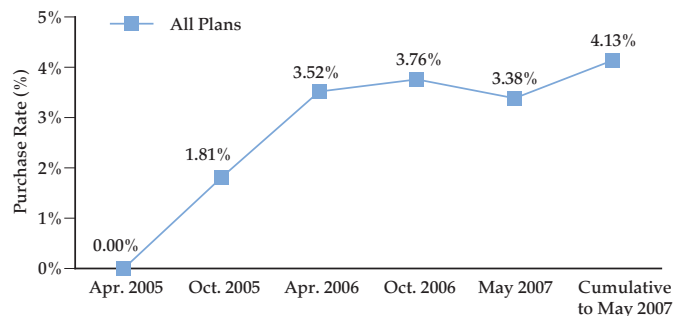
Source: HA/TMA-TRICARE Operations, 5/10/2007

A special study focused specifically on Tier 1 Plans from inception to May 2007. After examining purchase rates for TRS, information coincided with a substantial change resulting in a single-tiered program beginning October 2007. The table below provides a summary of potential qualifying sponsors, plans purchased, and purchase rates in the TRS Tier 1 program between April 2005 and May 2007, and the line chart below presents the monthly plan purchase rate for the same time period.

The monthly number of TRS Tier 1 potential qualifying sponsors has steadily increased since the start of the TRS program, although there was a modest decline in recent months. As shown in the table, the number of potential qualifying sponsors increased from 198,621 in April 2005 to 255,015 a year later, peaked in October 2006 with more than 300,000, and declined slightly to about 298,000 in May 2007. Cumulatively since the start of the TRS program, there have been more than 431,000 unique potential qualifying sponsors.

TRS TIER 1 PLANS AND PURCHASE RATE: SELECTED MONTHS AND CUMULATIVE TO MAY 2007

Month	Potential Qualifying Sponsors	Total Plans Purchased	Plan Purchase Rate (%)
April 2005	198,621	0	0.00
October 2005	244,950	4,422	1.81
April 2006	255,015	8,977	3.52
October 2006	300,992	11,323	3.76
May 2007	297,922	10,077	3.38
Cumulative to May 2007	431,044	17,812	4.13



Source: HPA&E Analysis supported by RTI, International, 11/9/2007

TELEPHONE SURVEY OF ILL AND INJURED SERVICE MEMBERS POST-OPERATIONAL DEPLOYMENT AFTER SIX MONTHS

Ensuring that ill, injured, and wounded Service members are receiving high-quality health care is an extremely high priority of the Department. Part of receiving high-quality health care entails an effective and efficient Disability Evaluation System (in which Service members are in transition) such as the Army's Warrior Transition Unit. "Medical extension" for the Navy and "awaiting medical board" for the Air Force represent a similar status. Additionally, the Department is interested in the ill or injured Service member's access to, and perceptions of, health care and support services while involved in receiving outpatient care.

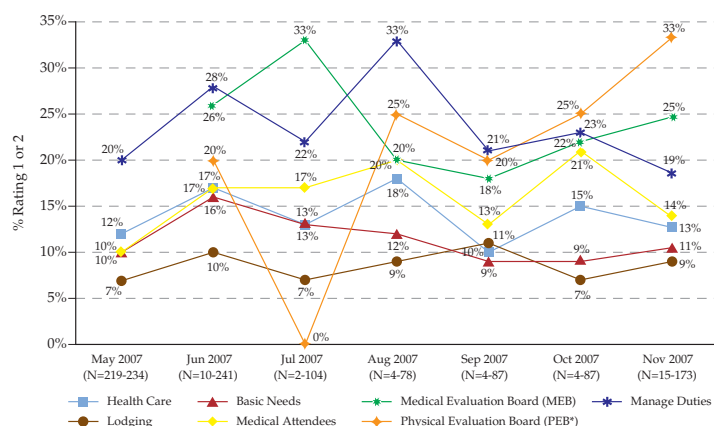
Beginning in May 2007, the Department began the monthly Telephone Survey of Ill or Injured Service Members Post-Operational Deployment in response to a Secretary of Defense tasking to establish a mechanism to identify and provide actionable information to the Services to resolve shortcomings related to Service members recuperating from illness or injury following return from operational deployment. Developed by the Military Health Services Survey Work Group chaired by OASD(HA)/TMA-Health Program Analysis and Evaluation with membership from staff of the Services Surgeons General, a survey was established for quickly fielding to ill or injured Service members returning from operational deployment overseas via aeromedical evacuation. The survey was designed for use in a computer-assisted telephone interviewing (CATI) system. CATI is a telephone surveying technique in which the interviewer follows a script provided by a software application. The software is able to customize the flow of the questionnaire based on the answers provided, as well as information already known about the participant.

The sample frame for this monthly survey is designed as a census of all ill or injured Service members, U.S and overseas, flown out of operational theaters since December 1, 2006, and

not in an inpatient status at the time of the survey or returned to operational deployment. The monthly telephone survey was first fielded in May 2007, inquiring about Service member satisfaction with, and access to, health care and personnel support services while in medical hold (or holdover or Warrior Transition Unit) status, in the Disability Evaluation System, and using outpatient health care services.

- Of almost 6,400 Service members surveyed, more than 2,100 responded during the seven-month period from May to November 2007. These Service members were aeromedically evacuated from theater between December 1, 2006 and September 30, 2007 (averaging between 41–48 percent response rate each month and an overall adjusted response rate of more than 45 percent).
- The telephone survey is reaching almost "real time," with some Service members being called within 30 days of leaving the operational theater.
- Majority of surveys are Army (82 percent) and Marines (9 percent); majority of responses are Army (80 percent) and Marines (10 percent).
- The survey instrument relies mostly on a five-point Likert scale, with ratings from "1" (poor) to "5" (outstanding) used to rate experience with health care services or support.
- **Medical Hold/Holdover:** Almost one in four Service members continue to rate poorly two areas related to their medical hold/holdover experience: (1) Their "ability to manage their military duties and personal affairs" and (2) their "experience with the MEB process" (23–24 percent of Service members rate a 1 or 2 on a 5 point scale, with 1 = poor; 5 = outstanding). It's worth noting that between 40 percent and more than 70 percent of other service members rate the medical hold areas as a "4" or "5" (outstanding).

MEDICAL HOLD RATINGS
(HOLDOVER, WARRIOR TRANSITION UNIT, AND AWAITING DISABILITY EVALUATION)

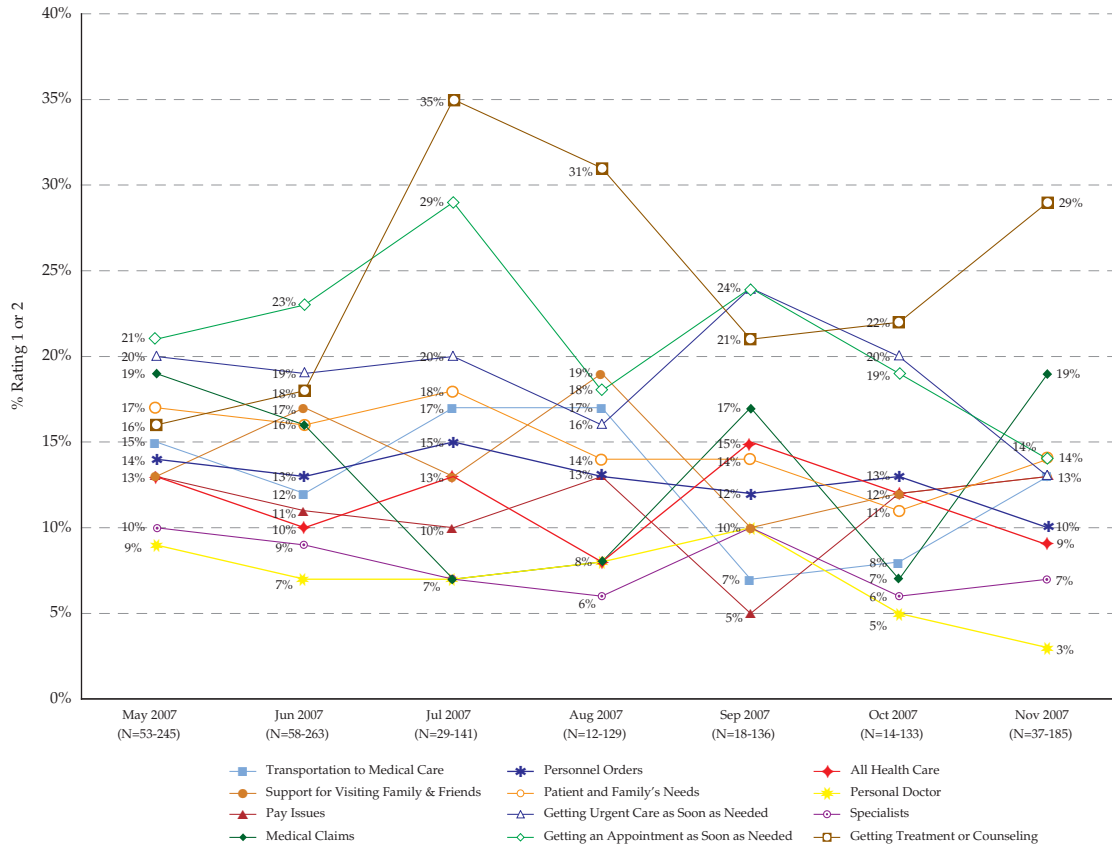


Source: HA/TMA monthly Ill or Injured Survey, as of 12/10/2007

Note: Very few Service members reported any experience with the PEB process each month, and none in July.

- **Health Care and other support when receiving outpatient health care services:** More than 1 in 5 Service members continue to rate poorly 3 of 12 questions, all related to accessing health care services: (1) "Getting an appointment as soon as needed," (2) "Getting urgent care as soon as needed" and (3) "Getting treatment or counseling for a personal or family problem," with 1 = poor; 5 = outstanding). Similar to medical hold findings, a high proportion of other Service members (between 60 percent and more than 80 percent, depending on the question) rate many of these areas as "4" or "5" (outstanding).

OUTPATIENT HEALTH CARE RATINGS OVER TIME

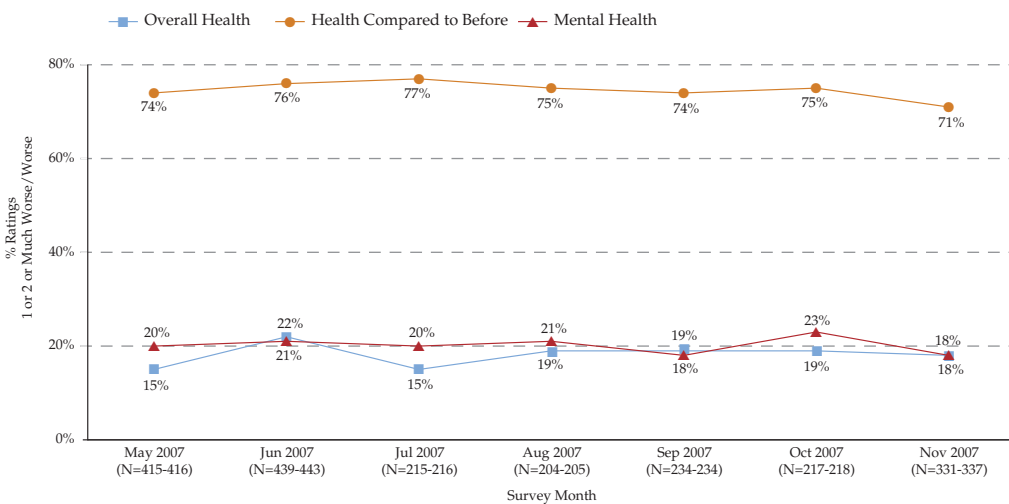


Source: HA/TMA monthly Ill or Injured Survey, as of 12/10/2007

➤ One in five personnel rate their current overall health and/or overall mental health as a 1 or 2 on a 5 point scale (1= poor; 5 = outstanding).

➤ Three-quarters indicate their health status is worse today than before they deployed.

DoD-WIDE SELF-REPORTED HEALTH STATUS RATINGS



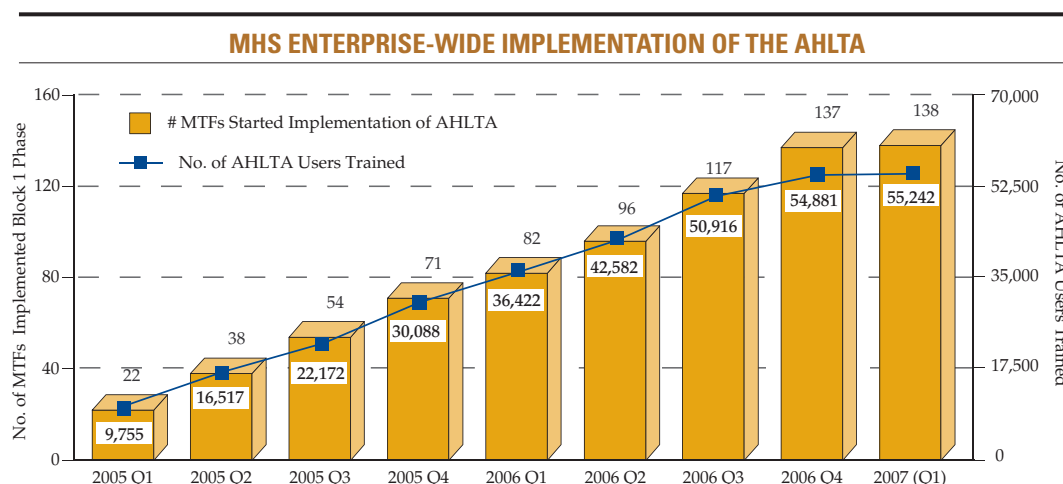
Source: HA/TMA monthly Ill or Injured Survey, as of 12/10/2007

TECHNOLOGY INITIATIVES

The DoD launched AHLTA, its electronic health record, enterprise-wide medical and dental clinical information system in January 2004, and completed the first phase of implementation in December 2006 as shown below. AHLTA supports more than 9.2 million MHS beneficiaries. By December 26, AHLTA was deployed in 138 DoD MTFs, involving 55,242 fully trained users (including 18,065 health care providers) in 11 time zones around the globe. It provides a centralized clinical data repository of beneficiary health information.

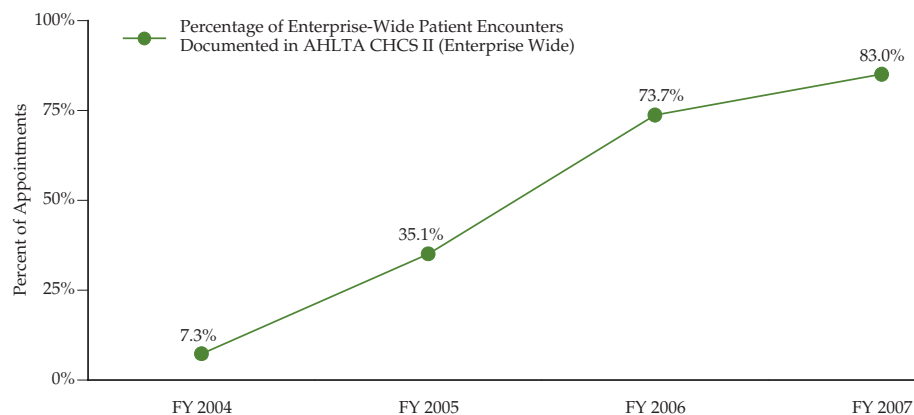
AHLTA marks a new era in health care for TRICARE beneficiaries and stands as a significant development in the electronic health record. AHLTA's capabilities will ultimately replace legacy systems, and replace or upgrade the inpatient system solution known as the Clinical Information System (CIS). The robust, standards-based interoperability provided by AHLTA is designed to allow seamless connectivity to deployed forces, sustaining the MHS and the VA. AHLTA Block 1 provides the foundation of system performance through a graphical user interface for real-time ambulatory encounter documentation. It enables retrieval of a beneficiary's health record at the point of care. Block 2 will integrate robust dental documentation and optometry orders management capabilities. Subsequent blocks will modernize legacy system ancillary services (laboratory, pharmacy, and radiology), order entry and results retrieval, inpatient documentation, and interface exchange with other MHS information support systems.

- Key metrics for monitoring the successful deployment of AHLTA focus on both the number of implementing MTFs as well as the training of staff using it. As of September 2006, AHLTA processed more than 30 million outpatient encounters, an average of almost 94,000 patient encounters per workday. Worldwide deployment of Block 1 was completed in December 2006.



Source: Clinical Information Technical Program Office, 11/23/2007

PERCENTAGE OF ENTERPRISE-WIDE PATIENT ENCOUNTERS DOCUMENTED IN AHLTA



Source: MHS Balanced Scorecard Instrument Panel, 12/26/2007

Another metric used to monitor the maturation of AHLTA focuses on the application of the capability for patient access with respect to recording patient encounters in the new system which feeds into the overall electronic health record. The chart to the left shows the MHS is making progress in recording patient encounters in AHLTA.

SHARING OF DoD INFORMATION WITH OTHER FEDERAL AGENCIES: DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE JOINT STRATEGIC EFFORTS

The Mission of the DVA and DoD Joint Strategic Plan is: To improve the quality, efficiency, and effectiveness of the delivery of benefits and services to Veterans, Service members, military retirees, and their families through an enhanced DVA and DoD partnership.

The Vision Statement for this effort is: A world-class partnership that delivers seamless, cost-effective, quality services to beneficiaries and value to our nation.

The Guiding Principles for this strategic effort are:

- **Collaboration:** To achieve shared goals through mutual support of both our common and unique mission requirements.
- **Stewardship:** To provide the best value for our beneficiaries and the taxpayer.
- **Leadership:** To establish clear policies and guidelines for VA/DoD partnership, promote active decision-making, and ensure accountability for results.

Specifically, the Strategic Goals for FYs 2008–2010 are:

Goal 1: Leadership, Commitment, and Accountability
Promote accountability, commitment, performance measurement, and enhanced internal and external communication through a joint leadership framework.

Goal 2: High Quality Health Care
Improve the access, quality, effectiveness, and efficiency of health care for beneficiaries through collaborative activities.

Goal 3: Seamless Coordination of Benefits
Improve the understanding of, and access to, services and benefits that Uniformed Service members and Veterans are eligible for through each stage of their life, with a special focus on ensuring a smooth transition from Active Duty to Veteran status.

Goal 4: Integrated Information Sharing
Ensure that appropriate beneficiary and medical data is visible, accessible, and understandable through secure and interoperable information management systems.

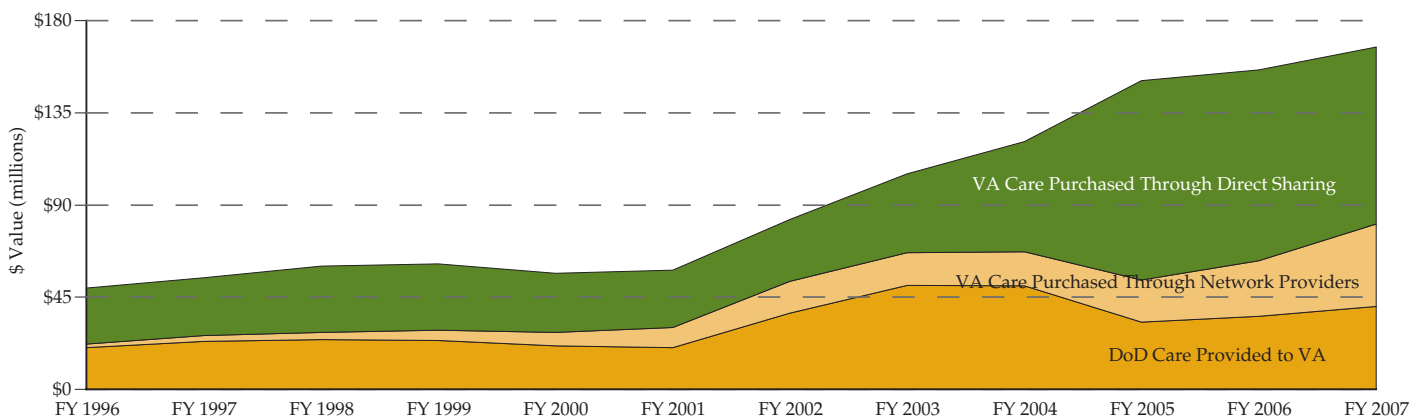
Goal 5: Efficiency of Operations
Improve management of capital assets, procurement, logistics, financial transactions, and human resources.

Goal 6: Joint Medical Contingency/Readiness Capabilities
Ensure the active participation of both agencies in Federal and local incident and consequence response through joint contingency planning, training, and conduct of related exercises.

With respect to the critical goals of leadership, commitment, and accountability (Goal 1) and seamless coordination of benefits (Goal 3), the extent of resource and health care service sharing has steadily increased over the past 11 years, and most rapidly within the past 6, as shown in the chart below:

With respect to integration information sharing (Goal 4), the VA and DoD strategic plan identifies the objective of utilizing interoperable enterprise architectures and data

DoD/VA SHARING: HEALTH CARE SERVICES (\$ MILLIONS)



Source: HA/TMA-DoD/VA sharing, as of 10/29/2007

SHARING OF DOD INFORMATION WITH OTHER FEDERAL AGENCIES: DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE JOINT STRATEGIC EFFORTS (CONT'D)

management strategies to support timely and accurate delivery of benefits and services. The emphasis will be on working together to store, manage, and share data, and streamline applications and procedures to make access to services and benefits easier, faster, and more secure. To that end, one of the subobjectives further states that information sharing metrics will include, but not be limited to:

- The number of DoD Service members with historical data transferred to VA;
- The number of patients flagged as “active dual consumers” for VA/DoD electronic health record data exchange purposes;
- The number of Pre-and Post-Deployment Health Assessment (PPDHA) forms and PDHRA forms transferred to VA;
- The number of individuals with PPDHA and PDHRA forms transferred to VA;
- Number of chemistry and anatomic pathology/microbiology laboratory tests processed using the Laboratory Data Sharing initiative;
- The number of patients for which digital images have been transmitted electronically from WRAMC, National Naval Medical Center Bethesda, and Brooke Army Medical Center to VA Polytrauma Centers at Tampa, Palo Alto, Richmond and Minneapolis; and
- The number of patients for which medical records have been scanned and sent electronically from WRAMC, National Naval Medical Center Bethesda, and Brooke

Army Medical Center to VA Polytrauma Centers at Tampa, Palo Alto, Richmond, and Minneapolis.

When the White House released the President's Management Agenda (PMA) scorecards for September 2007, DoD and VA collaboration scored a green for the first time in three years (White House release for September 2007 on October 26, 2007, at <http://mhs.osd.mil/mhsblog.jsp?messageID=66>).

The PMA scorecard demonstrates the progress of many people working hard to meet the goals in the DoD/VA Joint Strategic Plan. The scorecard reflects the Office of Management and Budget's (OMB) assessment of progress and uses a grading system with red, yellow, and green results, with green indicating successful implementation on schedule, and meeting objectives. A green indicator was also achieved for progress on the Health Information Technology scorecard.

OMB reviews quarterly progress toward bi-directional electronic medical records, military personnel data sharing, shared purchasing, joint education and training, and the coordinated separation process. Information sharing of health care data reported to the OMB, in addition to progress on scorecard milestones, is shown below.

OMB ASSESSMENT OF PROGRESS

	FY 2004*	FY 2005	FY 2006	FY 2007 (June 07)
Millions of unique patients for which DoD has transferred data to the FHIE repository	2.3	3.1	3.6	4
Number of DoD hospitals and medical centers where Bi-directional Health Information Exchange (BHIE) is operational (includes outpatient pharmacy data, allergy information, radiology text reports, laboratory results, and patients demographics)	1	5	33 Hospitals and 170 Clinics	42 Hospitals and 240 Clinics
Pre- and Post-Deployment Health Assessments forms sent electronically to VA	0	452,000	1,400,000	1,900,000
Number of sites with BHIE-Clinical Information System Interface which allows sharing of Inpatient Discharge Summaries	0	0	2	13
Number of sites operational with CHDR (Clinical Data Repository/Health Data Repository) which allows sharing of computable pharmacy and allergy data	0	0	3	7
FHIE transfer includes the following:				
Millions of laboratory results sent to VA			49.5	55.2
Millions of radiology reports sent to VA			8.2	9.1
Millions of pharmacy records sent to VA			49.7	55.7
Millions of standard ambulatory data records sent to VA			48.9	62
Millions of consultation reports sent to VA			1.4	1.8

Source: IMT&R, TMA quarterly report to OMB

* Estimated queries for 2004.

GENERAL METHOD

In this year's report, we compared TRICARE's effects on the access to, and quality of, health care received by the DoD population with the general U.S. population covered by commercial health plans (excluding Medicare and Medicaid). We made the comparisons using health care system performance metrics from the national CAHPS. The CAHPS program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care.

We also compared the effects of TRICARE on beneficiary utilization of inpatient, outpatient, and prescription services, as well as on MHS and beneficiary costs. Wherever feasible, we contrasted various TRICARE utilization and cost measures with comparable civilian sector benchmarks derived from the MarketScan® Commercial Claims and Encounters (CCAE) database provided by Thomson Healthcare Inc.

We made adjustments to both the CAHPS and CCAE benchmark data to account for differences in demographics between the military and civilian beneficiary populations. In most instances, we used the most recent three years of data (FY 2005–FY 2007) to gauge trends in access, quality, utilization, and costs.

Notes on methodology:

- Numbers in charts or text may not sum to the expressed totals due to rounding.
 - Unless otherwise indicated, all years referenced are Federal Fiscal Years (October 1 – September 30).
 - Unless otherwise indicated, all dollar amounts are expressed in then-year dollars for the Fiscal Year represented.
 - All photographs in this document were obtained from Web sites accessible by the public. These photos have not been tampered with other than to mask the individual's name.
 - Differences between MHS survey-based data and the civilian benchmark, or MHS over time, were considered significant at less than or equal to 0.05.
 - All workload and costs are estimated to completion based on separate factors for direct and purchased care. Because the purchased care completion factors were developed from historical claims experience, the completion factors for FY 2007 may be inaccurate if the claims experience under the new generation of contracts differs from the old.
- Data were current as of:
 - HCSDb/CAHPS—11/27/2007
 - MHS Workload/Costs—1/5/2008
 - Web sites uniform resource locators (urls)—2/27/08
 - TMA regularly updates its encounters and claims databases as more current data become available. It also periodically “retrofits” its databases as errors are discovered. The updates and retrofits can sometimes have significant impacts on the results reported in this and previous documents if they occur after the data collection cutoff date. The reader should keep this in mind when comparing this year's results with those from previous reports.

DATA SOURCES

Health Care Survey of DoD Beneficiaries (HCSDB)

To fulfill 1993 NDAA requirements, the HCSDB was developed by TMA. Conducted continuously since 1995, the HCSDB was designed to provide a comprehensive look at beneficiary opinions about their DoD health care benefits (source: TMA Web site: www.tricare.osd.mil/survey/hcsurvey/).

The HCSDB is composed of two distinct surveys, the Adult and the Child HCSDB, and both are conducted as large-scale mail surveys. The worldwide Adult HCSDB is conducted on a quarterly basis (every January, April, July, and October). The Child HCSDB is conducted once per year, from a sample of DoD children age 17 and younger.

Both surveys provide information on a wide range of health care issues such as the beneficiaries' ease of access to health care and preventative care services. In addition, the surveys provide information on beneficiaries' satisfaction with their doctors, health care, health plan, and the health care staff's communication and customer service efforts.

The HCSDB is fielded to a stratified random sample of beneficiaries. In order to calculate representative rates and means from their responses, sampling weights are used to account for different sampling rates and different response rates in different sample strata. Beginning with the FY 2006 report, weights were adjusted for factors, such as age and rank, which do not define strata but make some beneficiaries more likely to respond than others. Because of the adjustment, rates calculated from the same data differ from past evaluation reports and are more representative of the population of TRICARE users.

HCSDB questions on satisfaction with and access to health care have been closely modeled on the CAHPS program. CAHPS is a standardized survey questionnaire used by civilian health care organizations to monitor various aspects of access to, and satisfaction with, health care.

CAHPS is a nationally recognized set of standardized questions and reporting formats that has been used to collect and report meaningful and reliable information about the health care experiences of consumers. It was developed by a consortium of research institutions and sponsored by the Agency for Health Care Policy and Research. It has been tested in the field and evaluated for validity and reliability. The questions and reporting formats have been tested to ensure that the answers can be compared across plans and demographic groups. Because the HCSDB uses CAHPS questions, TRICARE

can be benchmarked to civilian managed care health plans. More information on CAHPS can be obtained at www.ahcpr.gov.

The HCSDB uses questions from CAHPS version 3.0 health plan survey. The results are compared to commercial health plan results from the National CAHPS Benchmarking Database (NCBD) for 2007. The NCBD collects CAHPS results voluntarily submitted by participating health plans and is funded by the U.S. Agency for Healthcare Research and Quality and is administered by Westat, Inc. Both benchmarks and TRICARE results are adjusted for age and health status. Differences between the MHS and the civilian benchmark were considered significant at p less than or equal to .05, using the normal approximation. The significance test for a change between years is based on the change in the MHS estimate minus the change in the benchmark, which is adjusted for age and health status to match the MHS. Beneficiaries' health plans are identified from a combination of self-report and administrative data. Within the context of the HCSDB, Prime enrollees are defined as those enrolled at least six months.

RWPs and RVUs are measures derived from inpatient and outpatient workload, respectively, to standardize differences in resource use as a means to better compare workload among institutions. RWPs, which are based on DRG weights and specific information on each hospital record, are calculated for all inpatient cases in MTFs and purchased care hospitals. They reflect the relative resource intensity of a given stay, with adjustments made for very short or very long lengths of stay and for transfer status. A comparison of total RWPs across institutions therefore reflects not only differences in the number of dispositions but in the case-mix intensity of the inpatient services performed there as well. RVUs are used by Medicare and other third-party payers to determine the comparative worth of physician services based on the amount of resources involved in furnishing each service. The MHS uses a modified version to reflect the relative costliness of the provider effort for a particular procedure or service.

Access and Quality

Measures of MHS access and quality were derived from the 2005, 2006, and 2007 administrations of the HCSDB. The comparable civilian-sector benchmarks came from the NCBD for 2007.

With respect to calculating the preventable admissions rates, both direct care and CHAMPUS workload were included in the rates. Admissions for patients under 18 years of age were excluded from the data. Each admission

DATA SOURCES (CONT'D)

was weighted by its RWP, a prospective measure of the relative costliness of an admission. Rates were computed by dividing the total number of dispositions/admissions (direct care and CHAMPUS) by the appropriate population. The results were then multiplied by 1,000 to compute an admission rate per 1,000 beneficiaries.

Utilization and Costs

Data on MHS and beneficiary utilization and costs came from several sources. We obtained the health care experience of eligible beneficiaries by aggregating Standard Inpatient Data Records (SIDRs—MTF hospitalization records); Standard Ambulatory Data Records (SADRs—MTF outpatient records); Health Care Service Records (HCSRs—purchased care claims information for the previous generation of contracts); TRICARE Encounter Data (TEDs—purchased care claims information for the new generation of contracts) for inpatient, outpatient, and prescription services; and TMOP claims within each beneficiary category. Costs recorded on HCSRs and TEDs were broken out by source of payment (DoD, beneficiary, or private insurer). Although the SIDR and SADR data indicate the enrollment status of beneficiaries, the DEERS enrollment file is considered to be more reliable. We therefore classified MTF discharges as Prime or space-available by matching the discharge dates to the DEERS enrollment file. Final data pulls used for this report were completed in early January 2008 as referenced above.

The Commercial Claims and Encounters database contains the health care experience of several million individuals (annually) covered under a variety of health plans offered by large employers, including preferred provider organizations, point-of-service plans, health maintenance organizations, and indemnity plans. The database links inpatient services and admissions, outpatient claims and encounters and, for most covered lives, outpatient pharmaceutical drug data and individual-level enrollment information. We tasked Thomson Healthcare Inc. to compute quarterly benchmarks for HMOs and PPOs, broken out by product line (MED/SURG, OB, PSYCH) and several sex/age group combinations. The quarterly breakout, available through the second quarter of FY 2007, allowed us to derive annual benchmarks by Fiscal Year and to estimate FY 2007 data to completion. Product lines were determined by aggregating Major Diagnostic Categories (MDCs) as follows: OB = MDC 14 (Pregnancy, Childbirth and Puerperium) and MDC 15 (Newborns and Other Neonates with Conditions Originating in Perinatal Period), PSYCH = MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders), and

MED/SURG = all other MDCs. The breakouts by sex and age group allowed us to apply DoD-specific population weights to the benchmarks and aggregate them to adjust for differences in the DoD and civilian beneficiary populations. We excluded individuals age 65 and older from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.

ABBREVIATIONS

AC	Active Component	GEIS	Global Emerging Infections Surveillance and Response System	PPO	Preferred Provider Organization
ACS	American Cancer Society			PRISM	Provider Requirement Integrated Specialty Model
AD	Active Duty	GWOT	Global War on Terrorism	RC	Reserve Component
ADFM	Active Duty Family Member	HA	Health Affairs	RVU	Relative Value Unit
AHLTA	Armed Forces Longitudinal Technology Application	HCSDB	Health Care Survey of DoD Beneficiaries	RWP	Relative Weighted Product
AMI	Acute Myocardial Infarction	HCSR	Health Care Service Record	SADR	Standard Ambulatory Data Record
ASD	Assistant Secretary of Defense	HIPAA	Health Insurance Portability and Accountability Act	SAMHSA	Substance Abuse and Mental Health Services Administration
BMI	Body Mass Index	HMO	Health Maintenance Organization	SIDR	Standard Inpatient Data Record
BRAC	Base Realignment and Closure	HP	Healthy People	TAO	TRICARE Area Office
CC	Complications and Comorbidities	HPA&E	Health Program Analysis and Evaluation	TAMP	Transitional Assistance Management Program
CAHPS	Consumer Assessment of Health Care Providers and Systems	HSA	Hospital Service Area	TDP	TRICARE Dental Program
CCAE	Commercial Claims and Encounters	IM/IT	Information Management/Information Technology	TED	TRICARE Encounter Data
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services	JMLIS	Joint Medical Logistics and Infrastructure Support	TFL	TRICARE for Life
CHCMS	Center for Health Care Management Studies	JTMC2	Joint Theater Medical Command and Control	TMA	TRICARE Management Activity
CHDR	Clinical/Health Data Repository	LOS	Length of Stay	TMOP	TRICARE Mail Order Pharmacy
CIS	Clinical Information System	MDC	Major Diagnostic Category	TOA	Total Obligational Authority
CMS	Centers for Medicare and Medicaid Services	MERHCF	Medicare-Eligible Retiree Health Care Fund	TOL	TRICARE Online
CONUS	Continental United States	MHS	Military Health System	TPR	TRICARE Prime Remote
DEERS	Defense Enrollment Eligibility Reporting System	MTF	Military Treatment Facility	TPRADFM	TRICARE Prime Remote for Active Duty Family Members
DHP	Defense Health Program	NAS	Nonavailability Statement	TRDP	TRICARE Retiree Dental Program
DHHS	U.S. Department of Health and Human Services	NCBD	National CAHPS Benchmarking Database	TRFDP	TRICARE Reserve Family Demonstration Project
DoD	Department of Defense	NDAA	National Defense Authorization Act	TRO	TRICARE Regional Office
DRG	Diagnosis-Related Group	NHE	National Health Expenditures	TRS	TRICARE Reserve Select
DTF	Dental Treatment Facility	OASD	Office of the Assistant Secretary of Defense	TSRx	TRICARE Senior Pharmacy
ESSENCE	Electronic Surveillance System for the Early Notification of Community-based Epidemics	OCONUS	Outside Continental United States	TRRx	TRICARE Retail Pharmacy
FDA	U.S. Food and Drug Administration	OHI	Other Health Insurance	UCCI	United Concordia Companies Inc.
FFS	Fee for Service	O&M	Operations and Maintenance	UMP	Unified Medical Program
FHIE	Federal Health Information Exchange	PCM	Primary Care Manager	USFHP	Uniformed Services Family Health Plan
FTE	Full-Time Equivalent	PDHRA	Post-Deployment Health Reassessment	VA	Department of Veterans Affairs
FY	Fiscal Year	PDS	Pharmacy Data Transaction Service	WHO	World Health Organization
GDP	Gross Domestic Product			YTD	Year To Date

To enhance DoD and our Nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.

